COMBINED INSURANCE COMPANY OF AMERICA

Home Office: Chicago, Illinois

Application for Hospital Indemnity Coverage

FORM 12904R-MD

I am applying for this coverage based on the following information:

EMPLOYEE'S (Proposed Insured) NAME (First MI Last)	☐ Male ☐ Female	Birthdate: Mo/Day/Yr	State of Birth
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)	Home Phone No.		Social Security No.
Name of Business or Employer	Hire Date: Mo/Day/Yr		Employee ID#

AMOUNT OF INSURANCE BEING APPLIED FOR:

Note:
Children's benefits are 50% those of the Proposed Insured.

	Amounts	PREMIUM - Mode
Base Policy (Admission / Confinement)	/	Selected
Intensive Care Rider		Selected
Outpatient Surgery Rider (Major / Minor)	$500/$50	
Emergency Room Rider		
Spouse Rider	☐ Yes / No ☐	
Child Rider	☐ Yes / No ☐	

List Dependents below: TOTAL:

Name (list Spouse first, if applying for Spouse coverage)	Birthdate	Name	Birthdate

Qualification question:

To the best of your knowledge and belief, have you or your spouse (if applicable), or any of your children (if applicable) had any advice or treatment for cancer, malignant growth, diabetes, stroke, heart attack, or other heart condition within the last five years? Employee Y/N Spouse Y/N Children Y/N (if any, mark "Y")

Is this policy intended to replace any existing coverage? Yes ☐ No ☐

I understand that any insurance applied for will not take effect unless and until Combined approves my application, issues the contract, and receives the required premium.

In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application is true and complete to the best of my knowledge and belief.
2. I acknowledge receipt of the Outline of Coverage.

X Signature on file _____ Date: On file

Signature of Proposed Insured

I, the authorized agent, have on the date of application recorded the information as given to me by the Proposed Insured.

Signature of Licensed Agent Signature on file _____ Code # _____