COMBINED INSURANCE COMPANY OF AMERICA

Home Office: Chicago, Illinois

Application for Hospital Indemnity Coverage

FORM 12916-VA

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.

The undersigned Proposed Insured and agent certify that the Proposed Insured has read or had read to him or her, the completed application and that he or she realizes that any false statement or misrepresentation therein may result in loss of coverage under the policy.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

X Signature on file _____ Date: On file

Signature of Proposed Insured

Signature of Licensed Agent Signature on file _____ Code # _____