New Era Life Insurance Company

Application For Individual Basic Hospital-Surgical Expense Policy

P.O. Box 4884, Houston, TX 77210-4884 ✦ 1-800-552-7879

Application is hereby made by the named applicant for policy form H-0168.NE

Requested Effective Date:

A. APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE	OCCUPATION (DESCRIBE DUTIES)

MAILING STREET ADDRESS	CITY	STATE	ZIP

PHONE NO. (WORK)	PHONE NO. (HOME)	TELEPHONE INTERVIEW: BEST DAY AND TIME TO CALL:

B. SPOUSE INFORMATION (COMPLETE ONLY IF ELECTING COVERAGE)

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE	OCCUPATION (DESCRIBE DUTIES)

C. DEPENDENT INFORMATION (COMPLETE ONLY IF ELECTING COVERAGE)

CHILD 1 LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE

CHILD 2 LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE

CHILD 3 LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE

CHILD 4 LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX

HEIGHT	WEIGHT	SOCIAL SECURITY #	DATE OF BIRTH	AGE

If more space is required, attach application supplement sheet(s) and check this box ❑ (Additional sheet(s) must be signed and dated)

D. PREMIUM AND BENEFITS

Premium Mode: ❑ Monthly (PAC) ❑ Quarterly ❑ Semi-Annually ❑ Annually ❑ List Bill ❑ Monthly Direct Bill

Total Premium Amount Paid With Application: $_____

Calendar Year Deductible: ❑ $1,000 ❑ $2,500 ❑ $5,000

Aggregate Maximum Benefit Per Accident Or Sickness: ❑ $100,000 ❑ $250,000 ❑ $1,000,000

E. OPTIONAL BENEFITS

(1) Outpatient Benefit Rider: ❑ Yes ❑ No $2,000 or $4,000 ?_____

(2) Accident Expense Rider : ❑ Yes ❑ No

(3) Maternity Rider: ❑ Yes ❑ No

F. TOBACCO USAGE

Has anyone proposed for coverage used any form of tobacco within the past 36 months? ❑ Yes ❑ No, If yes, list name(s):_____

I acknowledge that misrepresentation of this tobacco usage information may render the policy null and void. Applicant's Signature: ✕_____

G. PROPOSED INSURED INFORMATION

		Yes	No
1.	Has any proposed Insured within the past ten years had any symptoms, diagnosis, consultation, treatment or taken any medication for (circle conditions and provide details to "yes" answers below): (a) Tuberculosis, emphysema, disease of lungs, bronchi, asthma, allergy, hay fever, sinus, or other respiratory problems? (b) High or low blood pressure, stroke, disease or disorder to the heart, circulatory system, blood, anemia, veins or arteries, shortness of breath & chest pain? (c) Disease or disorder of stomach, esophagus, intestines, liver, hepatitis, gall bladder, colon, chronic diarrhea, ulcer or eating disorders? (d) Fainting spells & headaches, paralysis, convulsions, epilepsy, seizures or disease or disorder of the brain, or nervous system? (e) Disease or disorder of kidneys, ureters, bladder, urethra, prostate, rectum? (f) Rheumatism, arthritis, osteoporosis, gout, hernia, hemorrhoids? (g) Sexually transmitted disease of any kind? (h) Cancer, tumors, diabetes, lupus, goiter, disease or disorder of the thyroid, lymph or other glands, or pancreas? (i) Neck or back trouble, muscular disorder? (j) Glaucoma, cataracts, or disease or injury to eyes? (k) Any disease or disorder of the ears, nose, or throat?	❑	❑
2.	Are you and all other proposed insureds now in good health physically and mentally?	❑	❑
3.	Has any proposed insured within the past ten years miscarried, had an abortion, tumors or disease, or disorder of the breasts (including breast augmentation), uterus, tubes or ovaries or been treated for hormone imbalance, or oral contraceptive reactions of any kind?	❑	❑
4.	Is applicant or any dependent (whether or not named on application) pregnant or had a cesarean section within the past two years? Name/Due date:_____	❑	❑
5	Has any proposed insured within the past ten years been told or advised to have a series of tests or a surgical operation that was not performed?	❑	❑
6.	Has any proposed insured within the past ten years been treated for or diagnosed with alcohol or drug abuse?	❑	❑
7.	Has any proposed insured within the past ten years been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex or tested positive to the HIV test?	❑	❑
8.	Has any proposed insured within the last five years: (circle conditions and provide details to "yes" answers below) (a) been charged with a driving while impaired (alcohol, drug or other) violation, had a drivers license revoked or suspended, or within the last 24 months received 3 or more citations for moving traffic violations? (b) Had an application for insurance declined, postponed, or issued on a modified/rated/substandard basis? (c) Flown as a pilot, student pilot, or crewmember of any aircraft or have intentions to do so? (d) Engaged in parachuting, racing, or other hazardous sport or intend to do so? (e) Used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advice or treatment for alcohol or drug use?	❑	❑
9.	Has any proposed insured had an unusual or abnormal weight change in the past year?	❑	❑
10.	Does any proposed insured intend to reside outside the U.S.?	❑	❑
11.	Do you have an adoption pending?	❑	❑
12.	Is any proposed insured currently taking any prescription drugs?	❑	❑
13.	Has any proposed insured been convicted of a felony charge within the past 5 years?	❑	❑
14.	Do all applicants, other than dependent children, read, write, speak and understand the English language?	❑	❑

IMPORTANT – EXPLAIN ALL "YES" ANSWERS IN DETAIL TO ABOVE QUESTIONS (1) TO (14)

#	Applicant	Symptom / Condition	Dates	Name of Medication, Treatment, Advice, Results	Doctor's / Professional's Name, Address and Phone #

If more space is required, attach application supplement sheet(s) and check this box ❑ (Additional sheet(s) must be signed and dated)

H. APPLICANT'S REPRESENTATION

		Yes	No
(1)	Is the insurance applied for to replace or change any insurance in this or any other company?	❑	❑
	If "Yes", give Company Name and Policy/Certificate Number:_____		
(2)	I acknowledge receipt of the Outline of Coverage for the plan that I am applying for	❑	❑
(3)	Other health insurance coverage in force:_____		
(4)	Are all applicants applying for coverage US Citizens for at least 2 years? If not, please explain below: _____	❑	❑
(5)	Has an application for insurance been declined or postponed on any proposed insured? If yes, please explain below: _____	❑	❑

(6) How was this application obtained: In person ❑ other ❑

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of insurance fraud and may be subject to fines and confinement in prison.

I have read, or had been read to me, the completed application and realize that any false statement or misrepresentation in the application may result in loss of coverage, subject to the Incontestability provision, or affects the insurance company's acceptance of any person for coverage. I represent that the statements and answers given on this application are true, complete and correctly recorded. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to New Era Life Insurance Company or its reinsurers any information. A copy of this Authorization is as valid as the original. This authorization applies to dependents on whom insurance is requested.

X		X		X
Applicant's Signature	Date	Spousal Signature (If electing coverage)	Date	Agent Signature & Agent Number