



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

**APPLICATION FOR HOSPITAL INDEMNITY INSURANCE
POLICY FORM H-0180**

P.O. BOX 4884
HOUSTON, TX. 77210-4884

Issue State _____			
CALENDAR YEAR MAXIMUM BENEFIT	<input type="radio"/> \$100,000	<input type="radio"/> \$250,000	<input type="radio"/> \$1,000,000
NUMBER OF UNITS PER POLICY	<input type="radio"/> 1 UNIT	<input type="radio"/> 2 UNITS	<input type="radio"/> 3 UNITS
CALENDAR YEAR DEDUCTIBLE	<input type="radio"/> \$1,000	<input type="radio"/> \$2,500	<input type="radio"/> \$5,000
TOBACCO USER-APPLICANT:	<input type="radio"/> YES	<input type="radio"/> NO	TOBACCO USER-SPOUSE: <input type="radio"/> YES <input type="radio"/> NO

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE:	<input type="radio"/> MONTHLY (PAC)	<input type="radio"/> QUARTERLY	<input type="radio"/> SEMI-ANNUAL	<input type="radio"/> ANNUAL
PAYMENT TYPE:	<input type="radio"/> MONTHLY DIRECT BILL	<input type="radio"/> LIST BILL		

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.										
2.			SPOUSE							
3.			DEP.							
4.			DEP.							
5.			DEP.							
6.			DEP.							

RESIDENT ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (If different than Resident Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:			
APPLICANT: _____			
SPOUSE: _____			
HOSPITAL INDEMNITY INSURANCE PREMIUM			\$ _____
APPLICATION FEE (non-refundable)			\$ _____
TOTAL PAYMENT DUE.....			\$ _____
APPLICATION DATE	PRINT AGENT'S NAME (LAST, FIRST, MI)	AGENT NUMBER	PREMIUM

STATEMENT OF ELIGIBILITY AND OTHER INSURANCE

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO
IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.						
1. Has any Applicant ever had symptoms of, been diagnosed with or received treatment, tested or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B or C, insulin-diabetes including neuropathy, ulcerative colitis or Crohn's, Down's syndrome, mental retardation, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized more than 3 times in the past year?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
2. Has any Applicant ever tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
3. Is any household member-whether applying for coverage or not currently pregnant or have a pending adoption?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
4. Within the past 5 years has any applicant been diagnosed with, taken medication or been treated for internal cancer, malignant melanoma, or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
5. Within the past 4 years has any applicant been diagnosed with or received any medical treatment, taken medication for or been advised to have medical test for alcohol or drug abuse?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
6. In the past 6 months, has any family member been confined to a nursing facility (except for short term rehabilitation), bedridden, or been told they are disabled?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
7. Does any proposed insured intend to reside outside the U.S?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
<u>THE FOLLOWING QUESTIONS APPLY TO THOSE FAMILY MEMBERS THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>						
8. Has anyone to be insured used any form of tobacco (including cigars, pipe or chewing tobacco) within the past 24 months?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
9. In the last 12 months if any proposed insured been treated, tested or taken medication for any of the following conditions and <u>has seen a physician more than twice for any of these conditions? Please add one (1) point for each condition and underline the condition(s).</u>						
a. kidney stones, kidney/bladder or urinary infections, hepatitis A,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.(TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. depression, obsessive-compulsive disorder, psychosis, schizophrenia,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. migraines, cataracts, endometriosis, uterine fibroids or cyst.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If any proposed insured had a cesarean section, more than one miscarriage or seen a physician for infertility treatment and has not had a tubal-ligation or hysterectomy and is still of childbearing age, add two (2) points.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions? <u>Please add two (2) points for each condition(s) and underline the condition(s).</u>						
a. Emphysema and not smoking, non-insulin Diabetes, glaucoma,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Osteoarthritis, bariatric surgery (weight loss)-bypass, stapling, or lap band	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. cataracts or glaucoma, macular degeneration,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. cardiac ablation, epilepsy-seizures, hip or knee replacement,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. mitral valve prolapse, tachycardia-bradycardia or arrhythmia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. In the last 12 months, other than conditions mentioned above, has any applicant had any medical or surgical advice or treatment including prescriptions or operations or been advised to have medical test or surgery that has not yet been performed, or is awaiting medical test?	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>
13. Is there any other condition that will require a rate up? Please put the appropriate amount of point(s) in the box and provide details in the next section.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add total points from Question 9, 10, 11 and 13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ANY ANSWER TO ANY PART OF QUESTION 9, 10, 11, 12 or 13 IS "YES" FOR ANY APPLICANT, PROVIDE DETAILS BELOW

Applicant #	Nature of illness or Accident Include Diagnosis, Operations and Medications	Date Started	Date Ended	Surgery Y/N	Hospitalized From / To	Physician's Name, Address and Provide Number

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS. (Attach extra page if more space is needed)

APPLICANT #1'S DOCTOR NAME:		Phone Number			
ADDRESS	CITY	STATE		ZIP	
SPOUSE'S DOCTOR NAME:		Phone Number			
ADDRESS	CITY	STATE		ZIP	
CHILDREN'S DOCTOR NAME:		Phone Number			
ADDRESS	CITY	STATE		ZIP	

BENEFICIARY

Primary: _____ Relationship: _____
 Secondary: _____ Relationship: _____

"I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein. I acknowledge receipt of the Outline of Coverage and Disclosure Notice."

DATED AT CITY	STATE	MONTH	DAY	YEAR
SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANT'S		SIGNATURE OF SPOUSE, PARENT (IF MINOR), NEXT OF KIN OR LEGAL REPRESENTATIVE		
* _____		* _____		

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT *	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes