aetna®

# Outline of coverage

Protection Series℠–

## Cancer Plus Insurance Plan

**Policy Form CLICCAN18 TX or CLICCANR18 TX**

Underwritten by

**Continental Life Insurance Company of Brentwood, Tennessee**

An Aetna Company

**Texas**

aetnaseniorproducts.com

# CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
## HOME OFFICE

800 Crescent Centre Dr., Suite 200
Franklin, Tennessee 37067
1-800-264-4000

## SPECIFIED DISEASE COVERAGE

## REQUIRED OUTLINE OF COVERAGE

## RETAIN THIS OUTLINE FOR YOUR RECORDS

**READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your policy. This is not an insurance policy and only the actual policy provisions will control. Only the actual policy provisions will control. The policy sets forth in detail, the rights and obligations of both you and the insurance company. It is therefore, important that you READ YOUR POLICY CAREFULLY!

Specified disease coverage is designed to provide you with coverage paying benefits only when diagnosed with a covered specified disease. Coverage is provided for the benefits outlined in the Benefit Descriptions section. The benefits described in the Benefit Descriptions section may be limited by the Limitations and Exclusions section below.

### BENEFIT DESCRIPTIONS

#### LIMITED BENEFIT CANCERPOLICY FORM CLICCAN18 TX

We will pay the Cancer Benefit Amount to You for any Insured Person as detailed on the Schedule of Benefits page of the policy if the Insured Person is Diagnosed with Cancer or Cancer In Situ. This policy has a 30 day Benefit Waiting Period. Benefits may be selected in $5,000 increments to the policy's maximum benefit level of $75,000.

#### LIMITED BENEFIT CANCER POLICY WITH RECURRENCE BENEFIT FORM CLICCANR18 TX

We will pay the Cancer Benefit Amount to You for any Insured Person as detailed on the Schedule of Benefits page of the policy if the Insured Person is Diagnosed with Cancer or Cancer In Situ. This policy has a 30 day Benefit Waiting Period. Benefits may be selected in $5,000 increments to the policy's maximum benefit level of $75,000.

In addition, We will pay the Recurrence Benefit Amount, each time an Insured Person receives a Diagnosis for the Recurrence of Cancer subject to the Recurrence Benefit table on the Schedule of Benefits page of the policy and listed below. In order for any benefits to be payable, the Insured Person must not have received any Medical Advice or Treatment for at least two years prior to the date of Diagnosis of the Recurrence of Cancer.

If the Insured Person receives benefits payable for the Recurrence of Cancer that is less than 100% of the Cancer Recurrence Benefit Amount and later receives a Diagnosis for another Recurrence of Cancer, We will pay another Recurrence Benefit Amount, subject to the Lifetime Maximum Percentage as shown on the Schedule of Benefits page of the policy and listed below. In order for another benefit to be payable, the Insured Person must not have received any Medical Advice or Treatment for at least two years prior to the date of Diagnosis of the Recurrence of Cancer.

| RECURRENCE BENEFIT | |
|---|---|
| **TIME PERIOD WITHOUT MEDICAL ADVICE OR TREATMENT AND RECURRENCE** | **PERCENTAGE OF ABOVE BENEFIT AMOUNT** |
| Less than 2 years | 5% |
| 2 years or more but less than 5 years | 20% |
| 5 years or more but less than 7 years | 50% |
| 7 years or more but less than 9 years | 75% |
| 9 years or more | 100% |
| **Lifetime Maximum Percentage of the Cancer Recurrence Benefit Amount** | **100%** |

**LIMITATIONS AND EXCLUSIONS**

We will not pay any benefits for Losses that are caused by or the result of the Insured Person's:

1. Intentional self-inflicted injury;
2. Use of drugs or intoxicants unless taken under the direction of a Physician;
3. Being exposed to a declared or undeclared war, or any act of declared or undeclared war; or
4. Being treated or having services provided by a member of Your Immediate Family.

The policy provides benefits only for Cancer as listed on the Schedule of Benefits page. The following illnesses, conditions, diseases and injuries are excluded:

1. Skin cancer, other than malignant melanoma;
2. Premalignant conditions or conditions with malignant potential;
3. Any diseases or illnesses other than Cancer, even though other such diseases or illnesses may have been complicated, aggravated or be directly or indirectly affected or caused by Cancer.

**RENEWABILITY**

The policy is guaranteed renewable for life provided premiums are paid when due. Renewability is subject to payment of the policy maximum benefits.

**PREMIUM AGREEMENT**

Premiums for the policy may be changed. Any change in premium will apply to all covered persons with Your same policy type based on the issue state of Your policy. Any change in premium may occur on the next premium due date after You are given at least 30 days advance notice in writing of such change.

A Grace Period of 31 days from Your Premium Due Date will be allowed for late payment of premium. During such Grace Period, this Policy will not lapse as long as You pay Your full premium by the end of the Grace Period. During the Grace Period, the Policy continues in force. This Policy will lapse on the last day of the Grace Period if full premium is not paid by the end of the Grace Period

**PREMIUM INFORMATION**

**ANNUAL PREMIUM FOR THE CANCER POLICY PER $5,000 OF COVERAGE**

| Policy Form CLICAN18 | | | | |
|---|---|---|---|---|
| Cancer Only per 5K | | | | |
| Issue Age | Individual | Single Parent Family | Individual and Spouse | Family |
| **18-24** | $ 32.50 | $ 41.20 | $ 60.70 | $ 69.40 |
| **25-29** | $ 32.50 | $ 41.20 | $ 60.70 | $ 69.40 |
| **30-34** | $ 32.50 | $ 41.20 | $ 60.70 | $ 69.40 |
| **35-39** | $ 37.80 | $ 46.50 | $ 70.60 | $ 79.30 |
| **40-44** | $ 54.10 | $ 62.80 | $ 101.00 | $ 109.70 |
| **45-49** | $ 74.80 | $ 83.50 | $ 139.70 | $ 148.40 |
| **50-54** | $ 98.80 | $ 107.50 | $ 184.50 | $ 193.20 |
| **55-59** | $ 125.00 | $ 133.70 | $ 233.40 | $ 242.10 |
| **60-64** | $ 153.00 | $ 161.70 | $ 285.70 | $ 294.40 |
| **65-69** | $ 177.50 | $ 186.20 | $ 331.50 | $ 340.20 |
| **70-74** | $ 198.90 | $ 207.60 | $ 371.40 | $ 380.10 |
| **75-79** | $ 210.00 | $ 218.70 | $ 392.20 | $ 400.90 |
| **80-84** | $ 219.30 | $ 228.00 | $ 409.50 | $ 418.20 |
| **85-89** | $ 229.50 | $ 238.20 | $ 428.60 | $ 437.30 |

**ANNUAL PREMIUM FOR THE CANCER POLICY WITH RECURRENCE BENEFIT PER $5,000 OF COVERAGE**

| Policy Form CLICANR18 | | | | |
|---|---|---|---|---|
| Cancer with Recurrence-per $5K | | | | |
| Issue Age | Individual | Single Parent Family | Individual and Spouse | Family |
| **18-24** | $ 36.70 | $47.60 | $68.50 | $79.40 |
| **25-29** | $ 36.70 | $47.60 | $68.50 | $79.40 |
| **30-34** | $ 36.70 | $47.60 | $68.50 | $79.40 |
| **35-39** | $ 42.00 | $52.90 | $78.40 | $89.30 |
| **40-44** | $ 59.80 | $70.70 | $111.70 | $122.50 |
| **45-49** | $ 81.30 | $92.20 | $151.80 | $162.70 |
| **50-54** | $ 106.60 | $117.50 | $199.10 | $209.90 |
| **55-59** | $ 135.50 | $146.40 | $253.00 | $263.90 |
| **60-64** | $ 167.40 | $178.30 | $312.60 | $323.50 |
| **65-69** | $ 194.60 | $205.50 | $363.40 | $374.30 |
| **70-74** | $ 216.00 | $226.90 | $403.40 | $414.20 |
| **75-79** | $ 227.10 | $238.00 | $424.10 | $435.00 |
| **80-84** | $ 236.40 | $247.30 | $441.50 | $452.30 |
| **85-89** | $ 243.90 | $254.80 | $455.50 | $466.30 |

**Payment options**
You have a choice among several payment options or modes for paying your premium – annual, semi-annual, quarterly, and monthly bank draft. Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations, and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

**Payment Modes**
Annual.....Annual x 1
Semi-annual.....Annual x .52
Quarterly.....Annual x .265
Monthly.....Annual x .08333

## POLICY TERMINATION

The Policy Owner may cancel the policy at any time by sending Us a written request to cancel. Upon cancellation, We will return any unearned premium paid computed by using the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the policy was issued. Cancellation will be without prejudice to any claim originating before the effective date of cancellation.

Your Policy will terminate at 12:01 a.m. local time at Your state of residence on the earliest of the following dates:

1. The date We receive Your written request to cancel Your Policy or on a later date that is requested by You.
2. The last day of the Grace Period, if sufficient premium has not been paid by the end of the Grace Period. During the Grace Period, the Policy continues in force.
3. For form CLICAN18 TX, the date when the Benefit Amount has been paid for all Insured Persons. For form CLICANR18 TX, the date when the Cancer Benefit Amount and 100% of the Recurrence Benefit Amount have been paid for all Insured Persons.
4. The date of death of the Policy Owner, if there is no surviving spouse or Domestic Partner who is an Insured Person on the Policy.

## COVERAGE TERMINATION

An Insured Person's Coverage under The Policy will terminate:

1. On the date of death of the Insured Person;
2. For form CLICAN18 TX, on the date on which the Benefit Amount for that Insured Person has been paid. For form CLICANR18 TX, on the date on which the Cancer Benefit Amount and 100% of the Recurrence Benefit Amount for that Insured Person have been paid;
3. For a Child, on the date they no longer meet the eligibility requirements of a Child under The Policy;
4. For a Domestic Partner, on the date they no longer meet the eligibility requirements of a Domestic Partner under The Policy;
5. For a spouse, on the date of a valid decree of divorce;
6. The date the Policy terminates;
7. The date We receive Your written request to cancel Coverage for an Insured Person or on a later date that is requested by You; or
8. If an Insured Person is not eligible for Coverage due to a Diagnosis of Cancer prior to the Effective Date or before the expiration of the Benefit Waiting Period. We will refund the portion of premium paid for that Insured Person's Coverage.

Following termination of Coverage due to death, if the Insured Person was the Policy Owner and The Policy has Family Coverage or Individual and Spouse Coverage, the surviving spouse or Domestic Partner will be considered the Policy Owner.

# Application

Protection Series℠–

## Cancer and Heart Attack or Stroke Plus Insurance Plans

Policy Form CLICCAN18 TX or CLICCANR18 TX
Policy Form CLICHAS18 TX or CLICHASR18 TX

Underwritten by

**Continental Life Insurance Company of Brentwood, Tennessee**

An Aetna Company

**Texas**

aetnaseniorproducts.com

**Continental Life Insurance Company of Brentwood, Tennessee**
An Aetna Company
P.O. Box 14399
Lexington, KY 40512-9700

# Application for Cancer and Heart Attack or Stroke Plus Insurance Plans

from Continental Life Insurance Company of Brentwood, Tennessee



- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

**Please select one:** ○ New business
○ Reinstatement *Policy number* .....
○ Conversion *Policy number* .....

## 1. Proposed insured information

If policy is issued, the proposed insured will become the policy owner.

Full name of proposed insured *First, M.I., Last* | Phone

Residential address | Apt/suite number

City | State | Zip

Write your mailing address if different from your residential address.

Mailing address | Apt/suite number

City | State | Zip

E-mail | Social Security Number

Write the birthdate that is on the birth certificate.

Birth date *mm/dd/yyyy* | Age | ○ Male ○ Female

Beneficiary name | Relationship

***Domestic partner means your same sex or opposite sex domestic partner or civil union partner as defined by applicable law.**

### Additional proposed insureds

Family members include spouse or domestic partner* and unmarried child(ren) under age 26.

Full name of spouse *please print* | Social Security Number

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

Sex | Birth date *mm/dd/yyyy* | Age

Full name of child *please print*

If additional space is needed. Please use a separate sheet of paper and attach to the application.

Sex | Birth date *mm/dd/yyyy* | Age

**Policy delivery** *Select one*:
Agent: ○ Mail
Applicant: ○ Mail ○ Electronically

## 2. Benefits information

Benefits for Cancer coverage and Heart Attack or Stroke coverage are available in $5,000 increments up to $75,000

Requested effective date: .....

Type of coverage selected:

◯ Individual
◯ Individual and spouse (or domestic partner)
◯ Individual and child(ren)
◯ Family

| Plan selected: | Benefit amount: | Premium amount: |
|---|---|---|
| ◯ Cancer *or* | $..... | $..... |
| ◯ Cancer with recurrence benefit | $..... | $..... |
| ◯ Heart attack or stroke *or* | $..... | $..... |
| ◯ Heart attack or stroke with recurrence benefit | $..... | $..... |

Premium mode:

◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Monthly bank draft *(electronic funds transfer or List Bill only)*

Payment method:

◯ Check ◯ Electronic funds transfer ◯ List Bill *Billing file identifier* .....

Premium will be drafted upon policy issue.

Premium collected:

$.....

PAYMENT MODES

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly bank draft). Each payment mode, other than annual and monthly bank draft, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates.

The annual and monthly bank draft modes have the same total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You have the right to change your payment mode, among the modes available, during the life of your policy.

## 3. Health questions

COMPLETE THIS SECTION ONLY IF THIS IS AN APPLICATION FOR NEW BUSINESS OR REINSTATEMENT.

**If the answer to the question in section A is "yes" the application will be declined.**

**If any answers to the questions in section B are "yes" then the applicant is not eligible for Cancer coverage.**

**If any answers to questions in section C are "yes" the applicant is not eligible for Heart Attack or Stroke coverage.**

### A. Please answer the following question if you or any other person are applying for coverage.

**Have you or any other person applying for coverage:**

1. During the past ten (10) years, been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ◯ Yes ◯ No

### B. Please answer the following questions if applying for the Cancer benefit.

**Within the past five (5) years, have you or any other person applying for coverage under this policy:**

1. Been advised by a Medical Professional to have any tests or monitoring related to cancer, including but not limited to, PSA screenings, mammograms, colonoscopies and genetic screenings, that have not been completed, for which test results have not been received or had abnormal test results where cancer has not been ruled out or results are inconclusive? ◯ Yes ◯ No
2. Experienced any of the following, for which medical advice, diagnosis or treatment has not yet been obtained: unexplained weight loss; a lump, growth or tumor in a breast or elsewhere; or a change in a mole? ◯ Yes ◯ No
3. Diagnosed with or treated for or are currently seeking treatment by a medical professional including surgery, radiation or chemotherapy for leukemia, Hodgkin's Disease, lymphoma, melanoma, sarcoma, myeloma, or any internal cancer? ◯ Yes ◯ No

**Health questions** *continued*

### C. Please answer the following questions if you or any person are applying for the Heart Attack or Stroke benefit.

**Have you or any person applying for coverage:**

1. Within the past 6 months, been treated for, or received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? ○ Yes ○ No
2. Within the past 6 months received medical advice or consultation or had medical tests performed (including tests performed during a routine check-up) where the results were other than normal or are still pending? ○ Yes ○ No
3. Within the past 5 years, had or been advised to have: any form of heart surgery, or heart related surgery, coronary artery surgery; or angioplasty, pacemaker or defibrillator installed, or arteriogram ? ○ Yes ○ No
4. Within the past 5 years, received medical advice for, or ever taken prescribed medications for any disease (excluding high blood pressure), disorder or abnormality of the heart or circulatory system (which includes arteries, veins, lymphatic nodes and vessels)? ○ Yes ○ No
5. Within the past 5 years, received medical advice for, or taken prescribed medications for myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? ○ Yes ○ No

## 4. Replacement questions

Do you have any other health insurance in force? ○ Yes ○ No

| Type of coverage | Policy number | Company |
|---|---|---|
| | | |
| Type of coverage | Policy number | Company |
| | | |

Is the policy being applied for intended to replace any other insurance? ○ Yes ○ No

| Type of coverage | Policy number | Company |
|---|---|---|
| | | |

## 5. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

Proposed insured's name

.

Account owner name, if different than proposed insured's

.

Financial institution name

.

◯ Checking ◯ Savings

Routing number

.

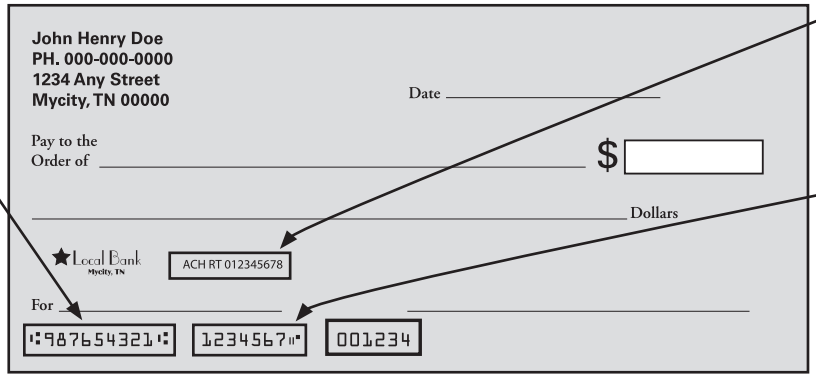
Account number

.

Requested EFT draft date

.

This is an example of a personal check. A business check may be different.




For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

## 6. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

**X**

Date

.

## 7. Applicant

I hereby apply to Continental Life Insurance Company of Brentwood, Tennessee for a policy to be issued in reliance on my written answers to the questions on this application. I have read or had read to me the completed application and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, the terms and conditions of the EFT authorization in Section 6 of this application are accepted.

**I understand that if any answers on this application are incorrect, incomplete or untrue, Continental Life Insurance Company of Brentwood, Tennessee has the right to adjust my premium, reduce my benefits. Any misrepresentations material to the risk on this application Continental Life Insurance Company of Brentwood, Tennessee has the right to rescind the policy.**

Applicant signature — Date signed

**X** .

Spouse signature *If applicable* — Date signed

**X** .

If accepted for coverage and requesting that the policy be delivered electronically by providing me access on the company's website, I understand and agree (1) to receive this insurance policy and related documents electronically, and (2) that I can obtain a paper copy of my policy at any time by requesting it from the company.

Applicant signature — Date signed

**X** .

Spouse signature *If applicable* — Date signed

**X** .

## 8. Privacy notice

Although your application is our initial source of information, we may collect information including health history and medical records from persons other than you, and we may conduct a telephone interview with you. Continental Life Insurance Company of Brentwood, Tennessee, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

## 9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our Companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

## 10. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the Proposed Insured.

1. List policies sold which are still in force

   .

   .

2. List policies sold in the past 5 years which are no longer in force

   .

   .

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for, and if 65 years of age or older, *A Guide to Health Insurance for People with Medicare* and a Non-Duplication of Medicare Disclosure to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

| Agent name *Printed* | Writing number (agent or company) |
|---|---|
| . | . |
| Agent signature | State license ID number (for FL only) |
| **X** | . |
| Phone | E-mail |
| . | . |

## 11. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

**Agent Information** *Print*

| Writing Agent | | Percentage |
|---|---|---|
| . | | . % |
| Secondary Agent | Writing number | Percentage |
| . | . | . % |
| Additional Agent | Writing number | Percentage |
| . | . | . % |

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

**X**

## 12. Fraud warnings

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or combination thereof.

**Arkansas and Louisiana and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of the insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or a deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

**Pennsylvania:** 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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Continental Life Insurance Company of Brentwood, Tennessee**
An Aetna Company

P.O. Box 14399
Lexington, KY 40512-9700

800-264-4000
aetnaseniorproducts.com
office hours 7:00 a.m. - 7:00 p.m. CST

# Initial premium receipt

from Continental Life Insurance Company of Brentwood, Tennessee



- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Be sure that all required sections of the application are completed. Any incomplete or missing information could delay processing of your application.

## Initial premium receipt

Applicant name *Printed*

Date of application *mm/dd/yyyy*

Electronic funds transfer (EFT) draft amount
$

Initial modal premium collected/drafted
$

Electronic funds transfer (EFT) draft date

This acknowledges receipt of the initial premium in connection with your application for a Continental Life Insurance Company of Brentwood, Tennessee Cancer and Heart Attack or Stroke Plus insurance policy.

Agent name *Printed*

Phone

Signature of agent

**X**

- Payment will be refunded for any coverage not issued.
- A recorded telephone interview may be necessary as part of the underwriting on your application for insurance.
- All premium payments must be made payable to Continental Life Insurance Company of Brentwood, Tennessee.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.

A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Continental Life Insurance Company of Brentwood, Tennessee issues a policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued policy. No policy shall be effective until it has actually been issued by Continental Life Insurance Company of Brentwood, Tennessee.

**Thank you for choosing**
**Continental Life Insurance Company of Brentwood, Tennessee!**

aetna™

# Health information authorization



**800-264-4000**
aetnaseniorproducts.com

- Please read these statements carefully. Print clearly using blue or black ink.
- This is a HIPAA required authorization.
- Applicant / insured must submit a completed, signed copy to the home office.
- Applicant / insured should keep a copy for their records.

## Applicant / insured declarations

I authorize the use and disclosure of health information about me as described below.

**Health Information to be Used or Disclosed:** I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

**Who May Request or Use Information:** This information may be disclosed to and used and or disclosed by: Aetna and the members of its Affiliated Covered Entity ("Aetna ACE"). An Affiliated Covered Entity is a group of Covered Entities under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Aetna ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the Aetna ACE and as permitted by HIPAA and this authorization; Aetna ACE's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

**Who is Authorized to Disclose Information:** All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

**Purpose:** This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of Aetna's life and health insurance plans.

**Statements of Understanding:** I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to Aetna at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant / insured complete this section.

Signature of applicant / insured

**X**

Date

.

Printed name of applicant / insured

**X**

City

.

State

.

Zip

.

Policy number of insured (if known)

.

Continental Life Insurance Company of Brentwood, Tennessee
*An Aetna Company*
**P.O. Box 14399 • Lexington, KY 40512 • 800-264-4000**

## NOTICE TO APPLICANT
## REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Continental Life Insurance Company of Brentwood, Tennessee. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1.) Health conditions which you may presently have (pre-existing) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2.) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide basis for the company to deny any future claims. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

(4.) New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy depending upon the Benefits, may be higher than you are paying for your present policy.

(5.) The renewal provision of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

The above "Notice to Applicant" was delivered to me on _____.
Date

_____
Applicant's Signature

White and Yellow Copy: To be sent to Home Office with Completed Application.
Pink Copy: Given to applicant.