

SERFF Tracking Number: LFSC-126729384 State: Arkansas  
Filing Company: LifeSecure Insurance Company State Tracking Number: 46383  
Company Tracking Number: POL-LS-HR-0001 ST 09/10  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Hospital Recovery Insurance Policy  
Project Name/Number: HRIP/

## Filing at a Glance

Company: LifeSecure Insurance Company  
Product Name: Hospital Recovery Insurance Policy  
TOI: H21 Health - Other  
Sub-TOI: H21.000 Health - Other  
Filing Type: Form  
Implementation Date Requested: On Approval  
State Filing Description:

SERFF Tr Num: LFSC-126729384 State: Arkansas  
SERFF Status: Closed-Approved-Closed  
Co Tr Num: POL-LS-HR-0001 ST 09/10 State Status: Approved-Closed  
Reviewer(s): Rosalind Minor  
Authors: Sue Howard, Judy Lucas, Karilynn Bagnell  
Disposition Date: 08/27/2010  
Date Submitted: 08/03/2010  
Disposition Status: Approved-Closed  
Implementation Date:

## General Information

Project Name: HRIP  
Project Number:  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 08/27/2010  
Deemer Date:  
Submitted By: Sue Howard  
PPACA: Not PPACA-Related  
Filing Description:  
LifeSecure Insurance Company  
NAIC #77720  
Form Filing: LS-HR-0001 ST 09/10, Hospital Recovery Insurance Policy  
LS-HR-0051 ST 09/10, Schedule of Benefits

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: Forms have been filed and are pending approval.  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Explanation for Other Group Market Type:  
State Status Changed: 08/27/2010  
Created By: Karilynn Bagnell  
Corresponding Filing Tracking Number:

SERFF Tracking Number: LFSC-126729384 State: Arkansas  
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LS-HR-0250 ST 09/10, Hospital Recovery Insurance Application  
LS-HR-0052 ST 09/10, Hospital Recovery Insurance Outline of Coverage  
Actuarial Memorandum and Rates

LifeSecure Insurance Company is submitting the forms referenced above for your review and approval. These are new forms and do not replace anything previously approved by your Department. Subject forms have been filed in our domicile Michigan and are pending approval.

Policy LS-HR-0001 ST 09/10 will provide a Daily Benefit Amount, which will range from \$50 to \$1667, up to the Annual Benefit Bank for issue ages of . On January 1st of each year the Annual Benefit Bank will be restored to the full amount.

Schedule of Benefits LS-HR-0051 ST 09/10 will reflect the insured's benefits as selected. The brackets on this form indicate that they are variable and subject to change.

Application LS-HR-ST 09/10 may be used in different ways depending upon the method of sale and signature. The application is designed to be completed with or without an agent present depending on the marketing method. The application may be signed electronically, using a signature pad or stylus, voice authorization signature, Accept/Reject for internet direct-sales or wet signature with an agent. The variable materials have been bracketed and a Statement of Variability is included in the filing to explain the variations.

We are also requesting to reserve the right to print it on 8 ½ X 14 inches for use in direct-sales marketing.

Hospital Recovery Insurance Outline of Coverage LS-HR-0052 ST 09/10 provides a brief summary of benefits and limitations of Policy LS-HR-0001 ST 09/10.

The actuarial memorandum and rates are also included in this filing.

We trust these forms will meet with your requirements. Should you require further information, please contact XXXX at 810.220.8774 or showard@lifeseureltd.com.

Sincerely,  
Sue R. Howard  
Compliance Manager

## Company and Contact

### Filing Contact Information

Karilynn Bagnell, Senior Compliance Specialist kbagnell@lifeseureltd.com

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LifeSecure Insurance Company 810-220-8774 [Phone]  
 10559 Citation Drive 810-220-7707 [FAX]  
 Suite 300  
 Brighton, MI 48116

**Filing Company Information**

LifeSecure Insurance Company CoCode: 77720 State of Domicile: Michigan  
 10559 Citation Drive Group Code: 572 Company Type: Life, A & H  
 Suite 300 Group Name: BCBS of MI GRP State ID Number:  
 Brighton, MI 48116 FEIN Number: 75-0956156  
 (810) 220-8774 ext. [Phone]

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50/form x 4 forms  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
LifeSecure Insurance Company	\$200.00	08/03/2010	38482202
LifeSecure Insurance Company	\$50.00	08/04/2010	38515664

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2010	08/27/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	08/09/2010	08/09/2010	Sue Howard	08/09/2010	08/09/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Application	Karilynn Bagnell	08/23/2010	08/23/2010

*SERFF Tracking Number:* LFSC-126729384      *State:* Arkansas  
*Filing Company:* LifeSecure Insurance Company      *State Tracking Number:* 46383  
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*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* Hospital Recovery Insurance Policy  
*Project Name/Number:* HRIP/

## **Disposition**

Disposition Date: 08/27/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document (revised)	Application	Approved-Closed	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Individual Recovery Care Insurance Policy	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/09/2010

Submitted Date 08/09/2010

Respond By Date

Dear Karilynn Bagnell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Recovery Care Insurance Policy, LS-HR-0001 ST 09/10 (Form)

Comment:

Before final review is given to this product, please advise as to the states that have approved this product. If any state has disapproved the product, please advise as to why the product was disapproved.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/09/2010  
Submitted Date 08/09/2010

Dear Rosalind Minor,

### Comments:

We have filed this product in 29 states.

### Response 1

Comments: We have received 3 approvals and 2 objections (one for additional actuarial certification and one for policy language) which we are preparing additional informatoin to respond). We have not received any disapprovals.

### Related Objection 1

Applies To:

- Individual Recovery Care Insurance Policy, LS-HR-0001 ST 09/10 (Form)

Comment:

Before final review is given to this product, please advise as to the states that have approved this product. If any state has disapproved the product, please advise as to why the product was disapproved.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I trust this information will allow you to continue your review.

Please let me know if you have any questions or need additional information.

Sue R. Howard  
Compliance Manager

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*Product Name:* Hospital Recovery Insurance Policy  
*Project Name/Number:* HRIP/

Sincerely,  
Judy Lucas, Karilynn Bagnell, Sue Howard

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Product Name: Hospital Recovery Insurance Policy  
Project Name/Number: HRIP/

## Amendment Letter

Submitted Date: 08/23/2010

### Comments:

During implementation we noticed some fields from the application were missing. We are submitting a revised application. The changes to the new form include:

1. In Section A, the Increase in Benefits has been bracketed.
2. In Section A, added Gender: Male Female.
3. In Section C, the Daily Benefit Amount is variable and is explained in the Statement of Variability.
4. In Section F, added The Policy provides limited benefits. Review Your Policy carefully!
5. In Section F, added Misstatements to Incontestability.
6. In Section F, added NM to Caution statement.

We reserve the right to alter the format of the forms submitted without re-filing due to future technology changes (i.e.paper size, font, font type, line ending or page ending changes). Be assured that all minimum font size requirements will be met. Any changes to wording or content would be filed prior to approval.

An updated statement of variability is also attached.

Should you require further information, please contact me at 810.220.4644 or kbagnell@lifeseecurelhc.com.

Sincerely,

Karilynn Bagnell

Senior Compliance Specialist

### Changed Items:

#### Supporting Document Schedule Item Changes:

#### Satisfied -Name: Application

Comment:

LS-HR-0250 ST 10.10 - Application -.pdf

LS-HR 0250-V ST 10.10 - Statement of Variability.pdf

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## Form Schedule

### Lead Form Number: LS-HR-0001 ST 09/10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/27/2010	LS-HR-0001 ST 09/10	Policy/Cont ract/Fratern al	Individual Recovery Care Insurance Policy Certificate	Initial		50.100	LS-HR-0001 ST 09 10_Hospital Recovery Policy.pdf
Approved-Closed 08/27/2010	LS-HR-0051 ST 09/10	Schedule Pages	Schedule of Benefits	Initial			LS-HR-0051 ST 09.10 Schedule of Benefits.pdf



**LifeSecure Insurance Company**

A Stock Company  
10559 Citation Drive, Suite 300  
Brighton, Michigan 48116  
1-888-575-8246

**INDIVIDUAL HOSPITAL RECOVERY INSURANCE POLICY**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.** It is not intended to replace your present health insurance. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Us.

**THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE.** You have the right, subject to the terms of this Policy, to continue this coverage as long as You pay the required premiums on time. We cannot change any of the terms of Your coverage or benefits without Your consent.

**PREMIUM CHANGES.** You cannot be singled out for a rate increase due to a change in Your age or health status. We can, however, change premiums, but only if We change the premiums for all similar policies issued in the same state and on the same form as Your Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 60 days written notice before the effective date of a premium change, and We cannot increase Your premium more than once in a twelve month period.

**30-DAY FREE LOOK.** If for any reason You decide not to keep this Policy, simply return it to Us within 30 days after You receive it. We will treat the Policy as though it had never been issued. We will refund the full amount of any premium paid within 10 days following receipt of the returned Policy.

**PRE-EXISTING CONDITIONS LIMITATION.** This Policy includes a limitation for Pre-Existing Conditions. Any Pre-Existing Condition as defined in Section 6, that occurred within 12 month (NV & WY residents – 6 month) period before the Policy Effective Date will not be covered for the first 6 months after the Policy Effective Date.

**CAUTION: THIS IS A LIMITED BENEFIT POLICY – PLEASE READ IT CAREFULLY!**

**This policy provides limited supplemental benefits and is not intended to cover all medical expenses.** The issuance of this limited benefit Individual Hospital Recovery Insurance Policy is based upon Your responses to questions on the Application. A copy of Your Application is enclosed. Please read it carefully. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind the Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the address shown above.

Secretary

A handwritten signature in cursive script that reads "Sara Hogan".

President

A handwritten signature in cursive script that reads "Lisa Wendt".

This is a non-participating Policy.

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SECTION 6: Glossary	8
<b>Schedule of Benefits</b>	Enclosed
<b>A copy of Your Application for this Policy</b>	Enclosed
<b>Any appropriate Riders, Endorsements or Notices</b>	Enclosed

Refer to the Schedule of Benefits to determine Your benefits, options and applicable coverage details.

**Note:** *This Policy contains terms that have a special meaning when applied to Your coverage. To help You recognize these terms, each word is capitalized wherever it appears throughout the Policy. These terms either: 1) appear in the Glossary (Section 6) with a corresponding definition; and/or 2) appear in a heading or sub-heading within the Policy with accompanying text providing further explanation.*

## **SECTION 1: DESCRIPTION OF BENEFITS AND FEATURES**

### **Annual Benefit Bank**

Your Schedule of Benefits shows the Annual Benefit Bank and the Daily Benefit Amount You have selected. Your Annual Benefit Bank represents the total dollar benefit amount available to You under this Policy each year. Your Daily Benefit Amount shows the amount We will pay to You for each day you were Confined in a Hospital.

Your Annual Benefit Bank balance is reduced by all benefit amounts paid to You. On January 1<sup>st</sup> of each year, We will restore Your Annual Benefit Bank to the full amount shown on Your Schedule of Benefits.

### **Benefit Payout Structure**

#### **Covered Expenses**

Your Schedule of Benefits shows the Daily Benefit Amount You will receive upon discharge, for each day You were Confined as an Inpatient in a Hospital. When You are eligible for benefits, as described in Section 2 of this Policy, We will pay benefits to You upon discharge based on the number of days You were Confined in a Hospital up to an annual calendar year maximum equal to Your Annual Benefit Bank limit.

## **SECTION 2: BENEFITS ELIGIBILITY AND CLAIMS PROCESS**

### **Eligibility Requirements**

We will pay the Daily Benefit Amount shown on Your Schedule of Benefits for each day you were Confined in a Hospital when We verify that You meet all of the following conditions:

- You were Confined as an Inpatient in a Hospital;
- You were discharged from the Hospital;
- Coverage under this Policy was in force on the date(s) You were discharged from the Hospital; and
- You have not exhausted Your Annual Benefit Bank.

### **Your Role/Claim Requests (Notice of Claim)**

We recommend You tell Us immediately, or as soon as reasonably possible, when You become aware You will be confined as an Inpatient in a Hospital. Written Notice of Claim must be given to Us within 120 days after You are discharged from the Hospital. If notice is not given within that time, it must be given as soon as reasonably possible.

Once You are discharged from the Hospital, You or Your Representative must notify Us or Our authorized agent, to submit Your claim request. You can notify Us by using the mailing address, phone number or e-mail address as follows:

LifeSecure Administrative Office ATTN: Claims Department P. O. Box 13490 Pensacola, FL 32591-3490 1.888.575.8246 E-mail: <a href="mailto:claims@YourLifeSecure.com">claims@YourLifeSecure.com</a>
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### ***Claims Notification and Decision (Proof of Loss)***

When We receive Your claim request, We will provide a claim form to You. If We do not provide a claim form to You within 15 days (GA residents – 10 days) of Your request, it will be deemed that You have met the requirement for Proof of Loss by giving us a written statement of the cause, nature and extent of Your Confinement within the time stated above.

You will need to submit proof of Confinement as an Inpatient in a Hospital. Written proof must be given to Us within 120 days (HI residents – 15 months; NC residents – 180 days) after You are discharged from the Hospital. If it is not reasonably possible for You to give written notice in that time period, We will not reduce or deny the claim for this reason if You provide the proof as soon as reasonably possible. In any event, the proof of Confinement must be given no later than one year from the date You are discharged from the Hospital unless you were legally incapacitated.

Once We complete Our review of the information provided, We will notify You if We determine You are eligible for benefits as defined in the Eligibility Requirements at the beginning of this Section.

We will notify You within ten business days of receiving all the required information if Your claim request is denied. We will provide You with information related to the denial. We will provide a written explanation of the reasons and make available all information directly related to the denial within 30 days (GA residents – 15 days) of receipt of Your written or electronic request, unless such disclosure is prohibited under state or federal law.

### ***Appeal Process***

If You disagree with Our decision regarding Your claim, You can appeal. You may request in writing or electronically within 60 days of Our decision that We reconsider Your claim. You should submit any additional information that You feel We need to review Our decision. You should include the contact information for anyone You think We should contact to learn more about Your claim. You are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider Our decision and send You written or electronic notification of the results. If We deny Your appeal request and You wish to receive written or electronic information related to such denial, that information will be sent to You within 30 days of receipt of Your appeal request.

### **Benefits Availability and Payments**

#### **To Whom Benefits Are Payable (Time Payment of Claims)**

Once We determine You are eligible, benefits will be payable to You immediately. Any eligible benefits unpaid at Your death will be payable to Your estate. However, We reserve the right to pay up to \$1,000 (HI & VA residents – up to \$2,000; NC residents – up to \$3,000; and ND residents – up to \$5,000) of such benefits otherwise payable to Your estate directly to someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. Any payment made by Us in good faith according to this provision will discharge Us to the extent of the payment.

Only one Policy per person will be issued. If more than one Policy is issued to any one person (whether in one state or in more than one state), the amount of liability under the policy shall be limited only to the amount payable on that Policy bearing the highest Annual Benefit Bank and any premiums paid to the Us for excessive coverage shall be refunded to You or to Your estate.

All claims are payable in United State dollars only.

### **SECTION 3: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS**

#### **Exclusions**

No benefits will be payable under this Policy after Confinement in a Hospital for a Sickness or Injury that was directly or indirectly a result of:

- operating, learning to operate, or serving as a crew member of any aircraft; or
- engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing or any similar activities; or
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
- officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received; or
- an illness, treatment or medical condition that is due to war or act of war which is not an act of terrorism, whether declared or undeclared, while serving in the armed forces or any auxiliary unit; or
- participating in or attempting to participate in an illegal activity that is classified as a felony, whether charged or not (the term felony is as defined by the law of the jurisdiction in which the activity takes place); or
- dental treatment or plastic surgery for cosmetic purposes (this exclusion does not apply if the treatment of surgery is (a) due to an Injury; or (b) to restore normal bodily functions); or
- elective surgery that is not medically necessary; or
- normal pregnancy except for Complications of Pregnancy\*; or
- an illness, treatment or medical condition that results from an attempt at suicide, while sane or insane (CO & MO residents – while sane), or an intentionally self-inflicted injury (SD residents – an illness, treatment or medical condition that results from an attempt at suicide or self-inflicted injuries); or
- expenses for treatment for a mental or nervous disorder or disease; or
- being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice and instructions of a Licensed Health Care Provider; or
- care or services provided outside the United States of America, its territories or possessions, or Canada; or
- any Pre-Existing Conditions as defined in this Policy.

\*Complications of Pregnancy do not include a Cesarean section, premature delivery without incident, false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiable distinct Complication of Pregnancy.

## **SECTION 4: PREMIUM AND RENEWAL PROVISIONS**

### **Premium Payments**

You will pay premiums to Us or to one of Our agents. Your first premium is due on the Policy Effective Date as shown on Your Schedule of Benefits.

### **Grace Period**

There is a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. Your insurance under the Policy will remain in force during the Grace Period, unless We have been advised in writing by You or Your Representative that You want to cancel Your coverage prior to the end of the Grace Period.

### **Notification of Termination Due to Non-Payment of Premium**

If Your premium is due and unpaid at the end of the Grace Period, We will give notice of termination to You. The notice of termination will be sent at the end of the Grace Period and at least 35 days in advance of termination. This notice will state the amount of unpaid premium, the date by which premium must be paid, and the date the coverage is to terminate. Our notice will be sent prepaid by United States first class mail. We will consider You notified as of five calendar days after the date the notice is mailed by Us. If Your premium remains unpaid on the termination date stated in the notice, Your coverage will terminate as of the end of the Grace Period. Any benefits payable after the last date for which Your premium was paid will be reduced by the premium due from the date the last premium was paid to the date Your coverage under the Policy terminated.

### **Unpaid Premium**

When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

### **Reinstatement**

If Your coverage is terminated due to non-payment of premiums, You may apply for reinstatement by notifying Us. You will be asked to complete an Application and We have the right to require evidence of insurability. A completed Application must be received by Us within one year after the end of the Grace Period. (SC & VA Residents: A conditional receipt will be provided for any premium submitted with the application).

If We approve the Application, the Policy will be reinstated as of the approval date. The Policy will be reinstated on the 45th day (NM on the 30<sup>th</sup> day) after the date of the application unless We notify you sooner of our disapproval.

In all other respects, upon reinstatement You will have the same rights under the Policy as You had prior to the Premium Due Date of the defaulted premium. Any premiums that We accept for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

## **SECTION 5: GENERAL PROVISIONS**

### **Coverage Effective Date**

You will become covered under the Policy on the Policy Effective Date shown on Your Schedule of Benefits, subject to payment of the required full modal premium.

### **Coverage Termination Date**

Your coverage terminates on the first to occur of:

- the date of Your death; or
- the date You cancel Your coverage; or
- the last day of the Grace Period.

### **Entire Contract**

The entire contract consists of: the Policy, the Schedule of Benefits, Your Application and any riders or endorsements to the Policy that are issued by Us. This Policy is issued in consideration of the attached application and the payment in advance of the first premiums.

### **Contract Changes**

Any contract change made by Us must be signed by one of Our executive officers. No agent may modify or waive any of the terms of the contract. No change in the contract is effective until You accept the change in writing or electronically, with the following exceptions: a change in the premiums; a change which is required by law or regulation; or a change which does not reduce or eliminate benefits or coverage. These exceptions do not include an increase in benefits or coverage with a like increase in premium. Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

### **Misstatements / Incontestability**

In issuing this Policy, We have relied upon information presented by You in Your Application. If Your Policy has been in force for two years, We cannot rescind Your Policy or deny a claim due to misrepresentation alone, except in cases where We can show that You knowingly and intentionally misrepresented relevant facts relating to Your health in Your Application.

### **Misstatement of Age**

If Your age was misstated in Your Application, We will adjust Your premium to the correct amount for Your insurance at Your correct age as of the Policy Effective Date. The amount of the insurance shall not be affected, provided that any necessary adjustment in premium is made and collected.

### **Conformity With State Statutes / Severability**

Any provision of Your Policy which, on the Policy Effective Date, is contrary to the applicable laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such state laws.

### **Time Periods**

All time periods start and end at 12:01 a.m. in the time zone in which You reside.

### **Clerical Error**

Clerical error or delays in making entries on the records by Us or Our designees will not void Your coverage if Your coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You were otherwise not eligible. Such clerical error will also not extend Your coverage if Your coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

### **Physical Exam & Autopsy**

We, at Our own expense, shall have the right and opportunity to examine the person of anyone covered under the Policy when and as often as We may reasonably require during the pendency of a claim and to request an autopsy in case of death where it is not forbidden by law (MS residents –autopsy does not apply; SC residents –autopsy must be performed in SC).

### **Legal Actions**

No action may be brought to recover under this Policy until 60 days after proof of loss has been given to Us. No action can be brought more than three years (SC residents – 6 years) from the date written or electronic proof of loss was required to be given.

## **SECTION 6: GLOSSARY**

This Section provides the definitions of words and terms used in the Policy that have a special meaning when applied to Your coverage. To help You recognize these special words and terms, each word is capitalized wherever it appears throughout the Policy.

### **Application**

The written or electronic Application form provided by Us and completed by You when You apply for coverage.

### **Annual Benefit Bank**

The overall maximum benefit amount payable under Your Policy each calendar year. This amount decreases for benefits paid during the year. At the first of each calendar year, the Annual Benefit Bank amount will be restored to the original amount at time of issue.

### **Complications of Pregnancy**

Means a condition (when the pregnancy is not terminated) the diagnosis of which is distinct from pregnancy but which is adversely affected by pregnancy or caused by pregnancy, and include but are not limited to:

- Non-elective cesarean section;
- Acute nephritis;
- Nephrosis;
- Cardiac decomposition;
- Hyperemesis gravidarum;
- Pre-Eclampsia;
- Placenta praevia;
- Puerperal infection;
- Miscarriage;

- Toxemia;
- Missed abortion; and similar medical and surgical conditions of comparable severity; or
- Termination of ectopic pregnancy and spontaneous
- Termination of pregnancy occurring during a time that a viable birth is not possible; and
- Pernicious vomiting (hyperemesis gravidarum), pre-eclampsia and toxemia with convulsions (eclampsia of pregnancy).

Complications of Pregnancy cease upon termination of the pregnancy.

Complications of Pregnancy do not include:

- Cesarean delivery;
- False labor;
- Pre-term contractions of labor;
- Advance maternal age;
- Non-emergency caesarian section;
- Occasional spotting;
- Bed rest prescribed by a Licensed Health Care Provider during the period of pregnancy;
- Morning sickness;
- Similar conditions associated with the management of a difficult pregnancy not constituting a classifiable distinct complication.

### **Confinement or Confined**

The assignment to a bed as a resident Inpatient in a Hospital and be at the direction of and under the supervision of a Licensed Health Care Practitioner. Observation, emergency or outpatient rooms are not considered Confinement.

### **Covered Expenses**

Benefits paid to You after You are discharged for each day You were Confined as an Inpatient in a Hospital.

### **Daily Benefit Amount**

The dollar amount of benefits paid to You for each day You were Confined as an Inpatient in a Hospital. Your Schedule of Benefits shows the Daily Benefit Amount You will receive.

### **Hospital**

A lawfully operated institution which:

- Has resident facilities for sick and injured patients;
- Primarily provides diagnostic, medical and surgical treatment for a fee to sick or injured persons;
- Has 24 hour continuous nursing service by or under the supervision of a graduate registered nurse;
- Has at least one Licensed Health Care Practitioner on staff who is on call at any time; and
- Is accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, subject to the limitations in the paragraph below.

A Hospital is not an institution or part of an institution that primarily provides hospice care, rehabilitation, custodial, convalescent, skilled nursing, or rest care, a psychiatric unit, or a facility which primarily cares for the aged, drug addicts or alcoholics.

**Injury/Injured**

Bodily injury sustained which:

- Is directly caused by an accident, independent of all other causes;
- Has not been specifically excluded by name or description in this Policy;
- Is not caused or contributed to by Sickness; and
- Occurs while this Policy is in force for the Policyholder named on the Schedule of Benefits.

**Inpatient**

Confinement in a Hospital as a resident and under the care of a Licensed Health Care Practitioner.

**Licensed Health Care Practitioner**

Any of the following who is not a family member: a physician (as defined in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

**Medically Necessary**

The treatment, services or supplies necessary and appropriate for the diagnosis or treatment of Sickness or Injury based upon generally accepted medical practice and prescribed by a Licensed Health Care Practitioner which:

- Is considered to be necessary and appropriate for the diagnosis and treatment of the condition; and
- Is commonly accepted as proper care or treatment of the condition.

**Medicare**

Title XVIII of the Social Security Act as amended.

**Mental or Nervous Disorder**

Any neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of Your illness will be used.

**Policy**

The contract between You and Us.

**Policy Effective Date**

The date the coverage begins upon receipt of the first full modal premium.

**Policyholder**

The person named on the Schedule of Benefits.

**Pre-Existing Conditions**

A Pre-existing Condition is a sickness or injury for which, within the 12 month (NV & WY residents – 6 month) period before the effective date of the Policy, medical advice, consultation or treatment was

recommended or received, or for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment. Care or treatment caused by a Pre-Existing Condition will not be covered unless it begins more than 6 months after the effective date of this Policy.

**Premium Due Date**

Each date a premium is due, after the initial premium, in accordance with the terms of this Policy.

**Representative**

A person or entity legally empowered to represent You.

**Sickness**

A disease or illness which results in loss covered by this Policy. The sickness must begin while this Policy is in force for the Policyholder as shown on the Schedule of Benefits.

**We, Us, Our**

LifeSecure Insurance Company or the administrator it designates.

**You, Your or Yourself**

The Policyholder named on Your Schedule of Benefits.



**LifeSecure Insurance Company**  
 10559 Citation Drive, Suite 300  
 Brighton, MI 48116  
 1-888-575-8246

**SCHEDULE OF BENEFITS**

**Policyholder:** [John Smith  
 10 Main Street  
 Anytown, USA 11111]

**Policy Number:** [LS-0000001]

**Policy Effective Date:** [09/01/10]

**Issue Age:** [45]

**[Coverage Change  
 Effective Date: 07/01/10]**

**BENEFITS AND COVERAGE AMOUNTS**

Annual Benefit Bank: [\$750 - \$20,000]  
 Daily Benefit Amount: [(\$50 - \$1,6667)]

[OPTIONAL BENEFIT RIDERS]

[ _____	\$xxx.xx]

**PREMIUM INFORMATION**

Premium Payment Mode: [Monthly, Quarterly, Semi-annual, Annual]

**Premium Amount:** [\$###] per [month, quarter, semi-annual period, year,]  
 [\$### per payroll deduction]

SERFF Tracking Number: LFSC-126729384 State: Arkansas  
 Filing Company: LifeSecure Insurance Company State Tracking Number: 46383  
 Company Tracking Number: POL-LS-HR-0001 ST 09/10  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Hospital Recovery Insurance Policy  
 Project Name/Number: HRIP/

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	08/27/2010
<b>Comments:</b>		
<b>Attachment:</b> Certification of Compliance 8.10.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	08/27/2010
<b>Comments:</b>		
<b>Attachments:</b> LS-HR-0250 ST 10.10 - Application -.pdf LS-HR 0250-V ST 10.10 - Statement of Variability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved-Closed	08/27/2010
<b>Comments:</b>		
<b>Attachment:</b> LS-HR-0052 ST 09.10-Outline of Coverage.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	08/27/2010
<b>Bypass Reason:</b> N/A - Limited Benefit Supplemental Health product		
<b>Comments:</b>		

**ARKANSAS  
CERTIFICATION OF COMPLIANCE  
Policy Form LS-HR-0001 ST 09/10**

I, Stephan H. Kellar, Vice President, Chief Financial Officer & Chief Actuary, certify the enclosed policy forms – LS-HR-0001 ST 09/10 et. al., are in compliance with the following:

- AR Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance
  - Actuarial Memorandum, Rates and Company Guidelines and Underwriting procedures are in compliance to ensure compliance.
- AR Regulation 49 – Life & Health Guaranty Association – dissemination at the time of policy delivery of the Limitations & Exclusions under the Arkansas Life & Health Insurance Guaranty Association Act.
  - Company Procedures require Attachment A to be delivered with the Policy.
- Flesch Certification  
ACA 23-80-206
- ACA 23-79-138 Information to accompany policies.
  - This information has been included on the Schedule of Benefits



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Stephan H. Kellar, Vice President  
Chief Financial Officer & Chief Actuary

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08/03/10  
Date



# Hospital Recovery Insurance Application

Application for:  New Coverage  Reinstatement [ Increase of Benefits]

## Section A: Applicant Information [Print clearly – Use black or blue ink.]

Mr.  Mrs.  Ms.  Dr. Group Number (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Name (First, MI, Last) Date of Birth (mm/dd/yyyy) Social Security Number

\_\_\_\_\_  
Street Address Apt #

\_\_\_\_\_  
City State Zip Code Telephone

\_\_\_\_\_  
E-mail Address Gender:  Male  Female Height: \_\_\_ft. \_\_\_in. Weight: \_\_\_lbs.

## Section B: Medical Information

1. Have you been advised in the *last 12 months* by a Licensed Health Care Practitioner to have surgery, diagnostic tests or therapy which would require an inpatient hospital stay, and which has not yet been completed?  Yes  No
2. Are you currently bedridden, confined to a wheelchair, receiving home healthcare services, staying in a hospital or nursing home, or receiving medical assistance at an assisted living facility?  Yes  No
3. Have you been hospitalized 3 or more times in the *past 2 years*?  Yes  No
4. In the past two (2) years, have you been diagnosed with, treated for or received medical advice from a Licensed Healthcare Practitioner for:
  - a. Diabetes requiring insulin, Kidney Failure, Kidney Dialysis, Cirrhosis of the Liver, Hepatitis C, Multiple Sclerosis?  Yes  No
  - b. Cancer other than Basal Cell, Leukemia, Hodgkin’s Disease, Lymphoma, or Melanoma?  Yes  No
  - c. Congestive Heart Failure, Heart Surgery of any type, Stroke (CVA), Transient Ischemic Attack (TIA)?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease or the use of oxygen to assist in breathing?  Yes  No
  - e. Alzheimer’s Disease, Senile Dementia or Organic Brain Disease?  Yes  No
  - f. Having or testing positive for Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?  Yes  No

**(WI Residents: You are not required to report results of HIV tests taken at anonymous counseling and testing sites or the results of home test kits.)**

If you answered “**Yes**” to any part of any question in Section B, **PLEASE DO NOT CONTINUE.**

We regret that we cannot offer you insurance coverage at this time.

If you answered “**No**” to all questions in Section B, please **CONTINUE.**

**Section C: Coverage Selection**

**DAILY BENEFIT AMOUNT:** Enter a dollar amount between [\$XX to \$XXXX] \_\_\_\_\_  
*[For increases, please enter the requested increase amount only.]*

**[OPTIONAL RIDERS:]**

**Dependent Care Rider**

I elect the Dependent Care Rider.

Dependent Name	Date of Birth (mm/dd/yyyy)	Sex	Social Security Number
1. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
2. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
3. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
4. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
5. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____

I elect the \_\_\_\_\_ Rider.

I elect the \_\_\_\_\_ Rider.

**PREMIUM AMOUNT:**

\$ \_\_\_\_\_ Monthly      \$ \_\_\_\_\_ Quarterly      \$ \_\_\_\_\_ Semi-Annual      \$ \_\_\_\_\_ Annual

**Section D: Replacement Question**

All questions must be answered.

Will this policy replace any Health or Accident & Sickness Insurance presently in force with this or any other Company?  Yes  No

If "Yes", provide details:  
 Company Name: \_\_\_\_\_ Company Address: \_\_\_\_\_ - OR -  
 Individual or Group Policy Number: \_\_\_\_\_

[If "Yes", please also submit the required Notice to Applicant Regarding Replacement of Accident and Health Insurance Form.]

**Section E: Premium Payment Authorization**

*Note: If you submit premium with your application and we decline coverage or you choose not to purchase the policy, we will refund your premium to you within 30 days.*

**Premium Payment Frequency:**

annually       semi-annually       quarterly       monthly\*

[\*\$2.00 monthly fee applies if you selected Direct Bill (mail)]

**Premium Payment Method:**

Automatic Payroll Deduction       Direct Bill (Mail)       Monthly Electronic Funds Transfer (EFT)   
 Automatic Credit Card Payment

**Authorization for Automatic Payroll Deduction:** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my insurance premiums automatically from my payroll.

[Payroll System/Division: \_\_\_\_\_]

[Payroll Location: \_\_\_\_\_]

[Payroll Frequency: \_\_\_\_\_]

[Employee Number: \_\_\_\_\_]

**Authorization for EFT or Credit Card:** I authorize LifeSecure to electronically withdraw money from my account or credit card for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid, for any reason.

Name of Bank: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Account Type:  checking  savings

Account #: \_\_\_\_\_

Routing #: \_\_\_\_\_

**Credit Card:**

Select Card Type:  Visa  MasterCard  American Express  Discover Card

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name as it appears on Card: \_\_\_\_\_

**Section F: Applicant Authorization**

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement. Please read each statement carefully before providing your signature authorization.

**Acknowledgements:** I acknowledge that I have read the Notices to Applicant regarding the Fraud Notice and the Insurance Information Practices which appear in Section [H][G] of this Application. I acknowledge that I have reviewed my answers and statements to all sections of this Application. I represent that all information supplied here is true and complete to the best of my knowledge. I agree to notify LifeSecure of any change in my medical condition while my application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the first full premium for the issued policy has been paid. I understand that the policy will not take effect until my application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application. I acknowledge that I have received an Outline of Coverage.

**Authorizations:** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of my health to give to LifeSecure Insurance Company, or its reinsurer(s) any such information. This authorization shall be valid for 24 months (**OK & VA:** 30 months). I understand the purpose of this authorization is to allow LifeSecure Insurance Company to determine eligibility for this insurance. Any information obtained will not be released by LifeSecure Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application or as may be otherwise lawfully required.

**The Policy provides limited benefits. Review Your Policy carefully!**

**Caution:** I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy. (In SC: subject to the Misstatements/Incontestability provision in the Policy.) I understand that the policy applied for will not pay benefits for any loss incurred during the first 6 months after the issue date on account of disease or physical condition which I now have or have had in the past 12 months (NV, NM, & WY: 6 months).

I represent that I have signed the application in: \_\_\_\_\_  
City State

**Signature Method:**  
 Voice Authorization       Signature via Faxed Application       Signature via Signature Pad

1. **Clicking "Accept" below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**  
       Accept       Decline      \_\_\_\_\_  
Date  
Voice Authorization Code \_\_\_\_\_  
A copy of your voice authorization recording is available upon request.

2. **My signature below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**  
\_\_\_\_\_  
Signature Date  
\_\_\_\_\_  
Printed Name

3. **My signature below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**  
\_\_\_\_\_  
Signature Date  
\_\_\_\_\_  
Printed Name

4. **Clicking "Accept" below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**  
       Accept       Decline      \_\_\_\_\_  
Date

**[Section G: Agent Report]**

**Authorizations:** I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this application.

1. Clicking "Accept" represents my acknowledgement, acceptance and authorization for the statement above.

Accept                       Decline

\_\_\_\_\_  
Soliciting Agent's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

( \_\_\_\_\_ )  
Voice Authorization Code

2. My Signature below represents my acknowledgement, acceptance and authorization for the statement above.

\_\_\_\_\_  
Soliciting Agent's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Date

3. My Signature below represents my acknowledgement, acceptance and authorization for the statement above.

\_\_\_\_\_  
Soliciting Agent's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Date

**Case Split Information (if applicable)**

LifeSecure ID#	Agent Name	% Split	Contract #
----------------	------------	---------	------------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

## Section [H][G]: Notices to the Applicant

### FRAUD WARNING:

**[For All States Not Listed Separately Below:]** Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arkansas, Louisiana, Maryland, Rhode Island & West Virginia:** 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 a crime and may be subject to fines and confinement in prison.

To residents of **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 an 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 the 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.

To residents of **DC:** **WARNING 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.**

To residents of **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.

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

To residents of **Oklahoma:** **WARNING** – 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.

To residents of **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.

To residents of **Tennessee, Virginia & 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 include imprisonment, fines and denial of insurance benefits.

**INSURANCE INFORMATION PRACTICES:**

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding. Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company  
10559 Citation Drive, Suite 300  
Brighton, MI 48116

[info@YourLifeSecure.com](mailto:info@YourLifeSecure.com)

**MEDICAL INFORMATION BUREAU:**

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you. At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The address and phone number of the MIB's information office are:

Medical Information Bureau  
P.O. Box 105, Essex Station  
Boston, Massachusetts 02111

866.692.6901 (TTY 866.346.3642)

## **Statement of Variability**

### **Application – LS-HR 0250 ST 10/10**

The following items are bracketed and the variability is explained below

#### **Section A:**

The option for “Increase of Benefits” will show if LifeSecure decides to offer insureds the option to increase their benefits.

The words “Print clearly – Use black or blue ink” will appear only when the application is printed in paper format.

#### **Section C:**

The Daily Benefit Amounts are bracketed to allow for LifeSecure to market certain Daily Benefit Limits. The Amounts will vary between “\$50 and \$1667” and “\$85 and \$1667”.

The language “For Increases, please enter the requested increase amount only” will only appear if the applicant checks the Increase box above section A. The line will always appear in the paper application.

The Heading for Optional Riders will only appear if LifeSecure chooses to pursue filing and adding a rider to this coverage in the future once approval is received on such rider.

The “Dependent Care Rider” language will only appear if LifeSecure chooses to pursue adding a Dependent Care Rider to coverage in the future once approved by the Department of Insurance.

The information for Dependents (Name, Date of Birth, Sex, Social Security) are bracketed to allow for the material to be collected if LifeSecure decides to pursue offering a Dependent Care Rider.

We have chosen to leave room for other Rider expansion in the future.

#### **Section D:**

The bracketed text will only appear on the paper version of the application, or if the applicant selects “yes” during the electronic input process.

The line “If Yes, Please submit...” will appear in all instances when an agent is involved in the sale. It will not appear when the application is completed in a direct response method or without agent involvement.

#### **Section E:**

The words “annually, semi-annually, quarterly, and monthly” are bracketed if in the future LifeSecure only chooses to offer certain payment frequencies. The “\$2.00” fee language will appear if the monthly payment option appears

The Premium Payment Methods are bracketed if in the future LifeSecure chooses to only offer certain payment methods.

The language for the Authorization for Automatic Payroll Deduction and Authorization for EFT or Credit Card will appear when the payment method for each of those is listed. If the payment option is not selected as an option for LifeSecure to market, these paragraphs will not appear.

The options in the Payroll Authorization are bracketed and will only appear electronically if it is applicable to that person. It will always appear on the paper version.

The Credit Card types are bracketed so that we may remove types or offer different types as needed.

#### **Section F:**

Within the Acknowledgements section, the section reference [H][G] is bracketed. If an application is completed without an agent present, Section G will show. If an application is completed with an agent present, Section H will show.

The Signature Method field is bracketed and will only appear in an electronic agent sold application.

The Signature methods are bracketed and will appear depending on how the application is completed (i.e. electronic, via signature pad, wet signature, etc). Note that the numbers on the side of the signature method will not appear on any application, they are there for our use in explaining the variability to you.

Signature Methods:

Method #1 will appear only if the applicant signs the application electronically during electronic input of the application.

Method #2 will appear only on paper applications for a wet signature to be provided. It will not appear on the electronic applications.

Method #3 will appear only if the LifeSecure elects to use a signature pad or stylus for the applicant to sign the application.

Method #4 will appear only in the electronic screen shots that are filled out when the applicant is completing the application online.

#### **Section G:**

The heading of Section G will appear when the application is completed with the assistance of an agent whether electronically or by paper.

The Authorization section is bracketed and will appear when the application is completed with the assistance of an agent whether electronically or by paper.

The Signature Methods are bracketed and will appear in the following manner. Note that they are numbered for your reference and the numbers will not appear in any application form.

Method #1 will appear only when the application is completed with the assistance of an agent and is completed electronically.

Method #2 will appear only if LifeSecure elects to use a signature pad or stylus for the application, and the application is completed with the assistance of an agent.

Method #3 will appear only on the paper application. It will not appear on the electronic versions.

The Case split information is bracketed and will only appear when agents are involved in the sale.

**Section H/G:**

The Section title [H][G] is bracketed. If an application is completed without an agent present, Section G will be Notices to Applicant. If an application is completed with an agent present, Notices to Applicant will become Section H.

The Medical Information Bureau language is bracketed and will only appear if LifeSecure chooses to use the Medical Information Bureau for underwriting purposes in the future.



LifeSecure Insurance Company  
 A Stock Company  
 10559 Citation Drive, Suite 300  
 Brighton, MI 48116  
 (866) 582-7701  
[www.YourLifeSecure.com](http://www.YourLifeSecure.com)

**HOSPITAL RECOVERY INSURANCE POLICY  
 OUTLINE OF COVERAGE  
 Guaranteed Renewable for Life  
 Policy Form Series: LS-HR-0001**

**Keep this Outline for Your Records**

**This is not a Medicare Supplement Policy. If you are eligible for Medicare, please review the “Guide to Health Insurance for People with Medicare” available from Us.**

Name \_\_\_\_\_ Date \_\_\_\_\_

**THIS IS A LIMITED BENEFIT POLICY - READ YOUR POLICY CAREFULLY**

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

If for any reason You decide not to keep this Policy, simply return it to Us within 30 days after You receive it. We will treat the Policy as though it had never been issued. We will refund the full amount of any premium paid within 10 days following receipt of the returned Policy.

**1. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

**2. BENEFITS PROVIDED UNDER THIS POLICY.** This is a limited benefit Individual Hospital Recovery Insurance Policy. It pays a Daily Benefit Amount upon discharge for each day of Hospital Confinement up to the Annual Benefit Bank. The Annual Benefit Bank balance is reduced by all benefit amounts paid . The Annual Benefit Bank will restore to the full amount on January 1<sup>st</sup> of each calendar year. Benefits are subject to the Limitations and Exclusions and the following Eligibility Requirements:

- You were Confined as an Inpatient in a Hospital;
- You were discharged from the Hospital;
- Coverage under this Policy was in force on the date(s) You were discharged from the Hospital; and
- You have not exhausted Your Annual Benefit Bank.

**3. PRE-EXISTING CONDITIONS.** This Policy includes a limitation for Pre-Existing Conditions. A Pre-existing Condition is a sickness or injury for which, within the 12 month (NV & WY residents 6 month) period before the effective date of the Policy, medical advice, consultation or treatment was recommended or received, or for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment. Care or treatment caused by a Pre-Existing Condition will not be covered unless it begins more than 6 months after the effective date of this Policy.

**4. LIMITATIONS AND EXCLUSIONS.** No benefits will be payable under this Policy for Confinement in a Hospital for a Sickness or Injury that was directly or indirectly a result of:

- operating, learning to operate, or serving as a crew member of any aircraft; or
- engaging in hang-gliding, hot air ballooning, bungee jumping, parachuting, scuba diving, sail gliding, parasailing or any similar activities; or
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
- officiating, coaching, practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received; or

- an illness, treatment or medical condition that is due to war or act of war which is not an act of terrorism, whether declared or undeclared, while serving in the armed forces or any auxiliary unit; or
- participating in or attempting to participate in an illegal activity that is classified as a felony, whether charged or not (the term felony is as defined by the law of the jurisdiction in which the activity takes place); or
- dental treatment or plastic surgery for cosmetic purposes (this exclusion does not apply if the treatment of surgery is (a) due to an Injury; or (b) to restore normal bodily functions); or
- elective surgery that is not medically necessary; or
- normal pregnancy except for Complications of Pregnancy\*; or
- an illness, treatment or medical condition that results from an attempt at suicide, while sane or insane (CO & MO residents – while sane), or an intentionally self-inflicted injury (SD residents – an illness or medical condition that results from an attempt at suicide or self-inflicted injuries); or
- expenses for treatment for a mental or nervous disorder or disease or rehabilitation related to alcoholism or drug addictions; or
- being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice and instructions of a Licensed Health Care Provider; or
- care or services provided outside the United States of America, its territories or possessions, or Canada; or
- any Pre-Existing Conditions as defined in this Policy.

\*Complications of Pregnancy do not include a Cesarean section, premature delivery without incident, false labor, occasional spotting, prescribed bed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiable distinct Complication of Pregnancy.

5. **THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE.** You have the right, subject to the terms of this Policy, to continue this coverage as long as You pay the required premiums on time. We cannot change any of the terms of Your coverage or benefits without Your consent.

**6. RENEWAL, PREMIUM AND CANCELLATION PROVISIONS.**

**PREMIUM.** Your total annual premium for Your Policy is \_\_\_\_\_. You cannot be singled out for a rate increase due to a change in Your age or health status. We can, however, change premiums, but only if We change the premiums for all similar policies issued in the same state and on the same form as Your Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 60 days written notice before the effective date of a premium change and, We cannot increase Your premium more than once in a twelve month period.

**GRACE PERIOD.** There is a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. Your insurance under the Policy will remain in force during the Grace Period, unless We have been advised in writing by You or Your Representative that You want to cancel Your coverage prior to the end of the Grace Period.

**REINSTATEMENT.** If Your coverage is terminated due to non-payment of premiums, You may apply for reinstatement by notifying Us. You will be asked to complete an Application and We have the right to require evidence of insurability. A completed Application must be received by Us within one year after the end of the Grace Period. (SC & VA Residents: A conditional receipt will be provided for any premium submitted with the application).

If We approve the Application, the Policy will be reinstated as of the approval date. The Policy will be reinstated on the 45th day (NM on the 30<sup>th</sup> day) after the date of the application unless We notify you sooner of our disapproval.

In all other respects, upon reinstatement You will have the same rights under the Policy as You had prior to the Premium Due Date of the defaulted premium. Any premiums that We accept for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

**THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED. PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.**

<i>SERFF Tracking Number:</i>	<i>LFSC-126729384</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>LifeSecure Insurance Company</i>	<i>State Tracking Number:</i>	<i>46383</i>
<i>Company Tracking Number:</i>	<i>POL-LS-HR-0001 ST 09/10</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Hospital Recovery Insurance Policy</i>		
<i>Project Name/Number:</i>	<i>HRIP/</i>		

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
07/20/2010		Supporting Application Document	08/23/2010	LS-HR-0250 ST 09 10 - Application.pdf (Superseded) LS-HR 0250-V ST 09.10 - Statement of Variability.pdf (Superseded)



**LifeSecure Insurance Company**  
 10559 Citation Drive, Suite 300  
 Brighton, MI 48116  
 (866) 582-7701

## Hospital Recovery Insurance Application

Application for:  New Coverage  Reinstatement  Increase of Benefits

### Section A: Applicant Information [Print clearly – Use black or blue ink.]

Mr.  Mrs.  Ms.  Dr.

\_\_\_\_\_  
 Name (First, MI, Last) \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Social Security Number

\_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt #

\_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone

\_\_\_\_\_  
 E-mail Address \_\_\_\_\_ Group Number (If applicable) Height: \_\_\_\_ft.\_\_\_\_in. Weight:\_\_\_\_lbs.

### Section B: Medical Information

1. Have you been advised in the *last 12 months* by a Licensed Health Care Practitioner to have surgery, diagnostic tests or therapy which would require an inpatient hospital stay, and which has not yet been completed?  Yes  No
2. Are you currently bedridden, confined to a wheelchair, receiving home healthcare services, staying in a hospital or nursing home, or receiving medical assistance at an assisted living facility?  Yes  No
3. Have you been hospitalized 3 or more times in the *past 2 years*?  Yes  No
4. In the past two (2) years, have you been diagnosed with, treated for or received medical advice from a Licensed Healthcare Practitioner for:
  - a. Diabetes requiring insulin, Kidney Failure, Kidney Dialysis, Cirrhosis of the Liver, Hepatitis C, Multiple Sclerosis?  Yes  No
  - b. Cancer other than Basal Cell, Leukemia, Hodgkin’s Disease, Lymphoma, or Melanoma?  Yes  No
  - c. Congestive Heart Failure, Heart Surgery of any type, Stroke (CVA), Transient Ischemic Attack (TIA)?  Yes  No
  - d. Emphysema, Chronic Obstructive Pulmonary Disease or the use of oxygen to assist in breathing?  Yes  No
  - e. Alzheimer’s Disease, Senile Dementia or Organic Brain Disease?  Yes  No
  - f. having or testing positive for Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?  Yes  No

**(WI Residents: You are not required to report results of HIV tests taken at anonymous counseling and testing sites or the results of home test kits.)**

If you answered “**Yes**” to any part of any question in Section B, **PLEASE DO NOT CONTINUE.**  
 We regret that we cannot offer you insurance coverage at this time.  
 If you answered “**No**” to all questions in Section B, please **CONTINUE.**

**Section C: Coverage Selection**

**DAILY BENEFIT AMOUNT:** Enter a dollar amount between [\$50 to \$1,667] \_\_\_\_\_  
*[For increases, please enter the requested increase amount only.]*

**[OPTIONAL RIDERS:]**

**Dependent Care Rider**

I elect the Dependent Care Rider.

Dependent Name	Date of Birth (mm/dd/yyyy)	Sex	Social Security Number
1. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
2. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
3. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
4. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____
5. _____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	____-____-____

I elect the \_\_\_\_\_ Rider.

I elect the \_\_\_\_\_ Rider.

**PREMIUM AMOUNT:**

\$ \_\_\_\_\_ Monthly      \$ \_\_\_\_\_ Quarterly      \$ \_\_\_\_\_ Semi-Annual      \$ \_\_\_\_\_ Annual

**Section D: Replacement Question**

All questions must be answered.

Will this policy replace any Health or Accident & Sickness Insurance presently in force with this or any other Company?  Yes  No

If "Yes", provide details:

Company Name: \_\_\_\_\_ Company Address: \_\_\_\_\_ - OR -  
 Individual or Group Policy Number: \_\_\_\_\_

[If "Yes", please also submit the required Notice to Applicant Regarding Replacement of Accident and Health Insurance Form.]

**Section E: Premium Payment Authorization**

*Note: If you submit premium with your application and we decline coverage or you choose not to purchase the policy, we will refund your premium to you within 30 days.*

**Premium Payment Frequency:**

[  annually ]      [  semi-annually ]      [  quarterly ]      [  monthly\* ]

[\*\$2.00 monthly fee applies if you selected Direct Bill (mail)]

**Premium Payment Method:**

[  Automatic Payroll Deduction ]      [  Direct Bill (Mail) ]      [  Monthly Electronic Funds Transfer (EFT) ]  
 [  Automatic Credit Card Payment ]

**Authorization for Automatic Payroll Deduction:** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my insurance premiums automatically from my payroll.

[Payroll System/Division: \_\_\_\_\_]

[Payroll Location: \_\_\_\_\_]

[Payroll Frequency: \_\_\_\_\_]

[Employee Number: \_\_\_\_\_]

**Authorization for EFT or Credit Card:** I authorize LifeSecure to electronically withdraw money from my account or credit card for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid, for any reason.

Name of Bank: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Account Type:  checking  savings

Account #: \_\_\_\_\_

Routing #: \_\_\_\_\_

**Credit Card:**

Select Card Type: [  Visa ] [  MasterCard ] [  American Express ] [  Discover Card ]

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name as it appears on Card: \_\_\_\_\_

**Section F: Applicant Authorization**

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement. Please read each statement carefully before providing your signature authorization.

**Acknowledgements:** I acknowledge that I have read the Notices to Applicant regarding the Fraud Notice and the Insurance Information Practices which appear in Section [H][G] of this Application. I acknowledge that I have reviewed my answers and statements to all sections of this Application. I represent that all information supplied here is true and complete to the best of my knowledge. I agree to notify LifeSecure of any change in my medical condition while my application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the first full premium for the issued policy has been paid. I understand that the policy will not take effect until my application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application. I acknowledge that I have received an Outline of Coverage.

**Authorizations:** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of my health to give to LifeSecure Insurance Company, or its reinsurer(s) any such information. This authorization shall be valid for 24 months (**OK & VA:** 30 months). I understand the purpose of this authorization is to allow LifeSecure Insurance Company to determine eligibility for this insurance. Any information obtained will not be released by LifeSecure Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application or as may be otherwise lawfully required.

**Caution:** I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy. (In SC: subject to the Incontestability provision in the Policy.)

I understand that the policy applied for will not pay benefits for any loss incurred during the first 6 months after the issue date on account of disease or physical condition which I now have or have had in the past 12 months (NV & WY: 6 months).

I represent that I have signed the application in: \_\_\_\_\_  
City State

**Signature Method:**

Voice Authorization       Signature via Faxed Application]       Signature via Signature Pad]

**Clicking "Accept" below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**

Accept       Decline      \_\_\_\_\_  
Date

Voice Authorization Code \_\_\_\_\_

A copy of your voice authorization recording is available upon request.

**Clicking "Accept" below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**

Accept       Decline      \_\_\_\_\_  
Date

**My signature below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**

\_\_\_\_\_  
Signature      Date

\_\_\_\_\_  
Printed Name

**My signature below represents my acknowledgement, acceptance and authorization for all statements checked above. My authorized representative or I may request to receive a copy of this authorization.**

\_\_\_\_\_  
Signature      Date

\_\_\_\_\_  
Printed Name

**[Section G: Agent Report]**

**Authorizations:** I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this application.

Clicking "Accept" represents my acknowledgement, acceptance and authorization for the statement above.

Accept                       Decline

\_\_\_\_\_  
Soliciting Agent's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

( \_\_\_\_\_ )  
Voice Authorization Code

My Signature below represents my acknowledgement, acceptance and authorization for the statement above.

\_\_\_\_\_  
Soliciting Agent's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Date

My Signature below represents my acknowledgement, acceptance and authorization for the statement above.

\_\_\_\_\_  
Soliciting Agent's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
LifeSecure ID#

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Date

**Case Split Information (if applicable)**

LifeSecure ID#	Agent Name	% Split	Contract #
_____	_____	_____	_____
_____	_____	_____	_____

## Section [H][G]: Notices to the Applicant

### FRAUD WARNING:

**For All States Not Listed Separately Below:** Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arkansas, Louisiana, Maryland, Rhode Island & West Virginia:** 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 a crime and may be subject to fines and confinement in prison.

To residents of **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 an 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 the 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.

To residents of **DC:** **WARNING 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.**

To residents of **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.

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

To residents of **Oklahoma:** **WARNING** –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.

To residents of **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.

To residents of **Tennessee, Virginia & 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 include imprisonment, fines and denial of insurance benefits.

**INSURANCE INFORMATION PRACTICES:**

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding. Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company  
10559 Citation Drive, Suite 300  
Brighton, MI 48116

[info@YourLifeSecure.com](mailto:info@YourLifeSecure.com)

**MEDICAL INFORMATION BUREAU:**

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you. At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The address and phone number of the MIB's information office are:

Medical Information Bureau  
P.O. Box 105, Essex Station  
Boston, Massachusetts 02111

866.692.6901 (TTY 866.346.3642)

## **Statement of Variability**

### **Application – LS-HR 0250 ST 09/10**

The following items are bracketed and the variability is explained below

#### **Section A:**

The words “Print clearly – Use black or blue ink” will appear only when the application is printed in paper format.

#### **Section C:**

The Daily Benefit Amounts are bracketed to allow for LifeSecure to market certain Daily Benefit Limits. The Amounts shown are the minimum to maximum amounts that could be shown.

The language “For Increases, please enter the requested increase amount only” will only appear if the applicant checks the Increase box above section A. The line will always appear in the paper application.

The Heading for Optional Riders will only appear if LifeSecure chooses to pursue filing and adding a rider to this coverage in the future once approval is received on such rider.

The “Dependent Care Rider” language will only appear if LifeSecure chooses to pursue adding a Dependent Care Rider to coverage in the future once approved by the Department of Insurance.

The information for Dependents (Name, Date of Birth, Sex, Social Security) are bracketed to allow for the material to be collected if LifeSecure decides to pursue offering a Dependent Care Rider.

We have chosen to leave room for other Rider expansion in the future.

#### **Section D:**

The bracketed text will only appear on the paper version of the application, or if the applicant selects “yes” during the electronic input process.

The line “If Yes, Please submit...” will appear in all instances when an agent is involved in the sale. It will not appear when the application is completed in a direct response method or without agent involvement.

#### **Section E:**

The words “annually, semi-annually, quarterly, and monthly” are bracketed if in the future LifeSecure only chooses to offer certain payment frequencies. The “\$2.00” fee language will appear if the monthly payment option appears

The Premium Payment Methods are bracketed if in the future LifeSecure chooses to only offer certain payment methods.

The language for the Authorization for Automatic Payroll Deduction and Authorization for EFT or Credit Card will appear when the payment method for each of those is listed. If the payment option is not selected as an option for LifeSecure to market, these paragraphs will not appear.

The options in the Payroll Authorization are bracketed and will only appear electronically if it is applicable to that person. It will always appear on the paper version.

The Credit Card types are bracketed so that we may remove types or offer different types as needed.

#### **Section F:**

Within the Acknowledgements section, the section reference [H][G] is bracketed. If an application is completed without an agent present, Section G will show. If an application is completed with an agent present, Section H will show.

The Signature Method field is bracketed and will only appear in an electronic agent sold application.

The Signature methods are bracketed and will appear depending on how the application is completed (i.e. electronic, via signature pad, wet signature, etc). Note that the numbers on the side of the signature method will not appear on any application, they are there for our use in explaining the variability to you.

Signature Methods:

Method #1 will appear only if the applicant signs the application electronically during electronic input of the application.

Method #2 will appear only on paper applications for a wet signature to be provided. It will not appear on the electronic applications.

Method #3 will appear only if the LifeSecure elects to use a signature pad or stylus for the applicant to sign the application.

Method #4 will appear only in the electronic screen shots that are filled out when the applicant is completing the application online.

#### **Section G:**

The heading of Section G will appear when the application is completed with the assistance of an agent whether electronically or by paper.

The Authorization section is bracketed and will appear when the application is completed with the assistance of an agent whether electronically or by paper.

The Signature Methods are bracketed and will appear in the following manner. Note that they are numbered for your reference and the numbers will not appear in any application form.

Method #1 will appear only when the application is completed with the assistance of an agent and is completed electronically.

Method #2 will appear only if LifeSecure elects to use a signature pad or stylus for the application, and the application is completed with the assistance of an agent.

Method #3 will appear only on the paper application. It will not appear on the electronic versions.

The Case split information is bracketed and will only appear when agents are involved in the sale.

**Section H/G:**

The Section title [H][G] is bracketed. If an application is completed without an agent present, Section G will be Notices to Applicant. If an application is completed with an agent present, Notices to Applicant will become Section H.

The State Fraud Notices are bracketed and will only appear in the applicable states (on the electronic versions of the application), depending on the where the application is signed (Section F). The first fraud notice will appear in states that are not listed outright. The words "For All States Not Listed Separately Below" will only appear on the paper version of the application.

The Medical Information Bureau language is bracketed and will only appear if LifeSecure chooses to use the Medical Information Bureau for underwriting purposes in the future.