

# Application for Hospital Recovery Insurance and Regulatory Forms



This kit for use in the states of: **CA, IL, NY, TX**

# Application for Hospital Recovery Insurance

Signatures Required

## Instructions for Agent:

The Application must be entered on-line via LifeSecure's website.

- Enter the Application information into the LifeSecure Agent Portal at [www.YourLifeSecure.com](http://www.YourLifeSecure.com).
- Fax the signed paper Application to **1.866.582.7706**.

Please refer to the "LifeSecure Insurance Company – Hospital Recovery Agent Handbook" for additional information regarding our underwriting and application processes.



LifeSecure Insurance Company

10559 Citation Drive, Suite 300

Brighton, MI 48116

(866) 582-7701

## Hospital Recovery Insurance Application

Application for: ☐ New Coverage ☐ Reinstatement

### 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 (Note: Routine follow-up care to determine whether breast cancer has recurred in a person who has previously been determined to be free of breast cancer is not considered to be medical advice, diagnosis or treatment)? ☐ 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
5. In the past two (2) years, have you tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition not derived from such infections? ☐ Yes ☐ No

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 \$100 to \$999 \_\_\_\_\_  
*For increases, please enter the requested increase amount only.*

### PREMIUM AMOUNT:

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

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## 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.

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## 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 10 days.*

### Premium Payment Frequency:

☐ annually      ☐ semi-annually      ☐ quarterly      ☐ monthly

### Premium Payment Method:

☐ Automatic Payroll Deduction      ☐ Automatic Credit Card Payment  
☐ Monthly Electronic Funds Transfer (EFT) – Please select a draft date \_\_\_\_\_.

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

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

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

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

Account Type: ☐ checking ☐ savings

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

**Credit Card:**Select Card Type: ☐ Visa ☐ MasterCard

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

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**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 represent that all information supplied 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.

**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. 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. All authorizations may be revoked by You at any time.

**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. 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.

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

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.

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

\_\_\_\_\_  
Soliciting Agent’s Signature

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

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

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

\_\_\_\_\_  
State License Number

\_\_\_\_\_  
Date

Case Split Information (if applicable)

LifeSecure ID#	State License Number	Agent Name	% Split	Contract #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

\_\_\_\_\_

## Section H: Notices to the Applicant

### **FRAUD WARNING:**

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

### **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)

# Regulatory Forms

Forms must be left with client.

- Section H of Application (Notices to the Applicant)
- Outline of Coverage
- If coverage is being replaced:
  - a copy of the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance must be left with the client, and
  - a signed copy of the form must be faxed to LifeSecure at **1.866.582.7706** in order for the policy to be issued.



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 Us. 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. We will not pay more than Your Annual Benefit Bank for any one Confinement. 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 or died while in 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 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, provided however, that routine follow-up care to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer is not considered medical advice, consultation, diagnosis, care, or treatment for the purposes of determining whether a Sickness is a Pre-Existing Condition. 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
- 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 or an intentionally self-inflicted injury; or
- expenses for treatment for a mental or nervous disorder; 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.

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. The application for Reinstatement will be contestable for two years from the date of its approval. You will be required to pay the cost of any records that may be necessary to provide this evidence. If We approve the application, the new effective date of Your Policy will be determined as follows:

1. If the Application is approved within 60 days of the date of termination, the Reinstatement will be effective back to the date of termination. All unpaid premiums must be paid; or
2. If the Application is approved 61 days or more after the date of termination, the Effective Date will be the date the application is approved. The reinstated Policy will not cover any loss incurred prior to the Effective Date of Reinstatement.

Any premium accepted by Us or Our agent without requiring an Application shall reinstate the Policy.

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.

**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.**



## **LifeSecure Insurance Company**

LifeSecure Administrative Office

P.O. Box 12834

Pensacola, FL 32591

888.575.8246

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

According to Your Application, You intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a Policy to be issued by LifeSecure Insurance Company. For Your own information and protection, You should be aware of and seriously consider certain factors that may affect the insurance protection available to You under the new Policy.

- (1) Health conditions which You may presently have, (preexisting conditions) may not be immediately or fully covered under the new Policy. This could result in denial or delay of a claim for benefits present under the new Policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of Your present insurer or its agent regarding the proposed replacement of your present policy. This is not only Your right, but it is also in Your best interests to make sure You understand all the relevant factors involved in replacing Your present coverage.
- (3) If, after due consideration, You still wish to terminate Your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning Your medical/health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund Your premium as though Your Policy had never been in force. After the Application has been completed and before You sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

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

**Applicant: Please retain a copy of this form for your record.**



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