UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY

6640 S. Cicero Avenue
Bedford Park, IL 60638 • 800/875-4422

ARIZONA BENEFIT SELECTION SHEET

Please mark the appropriate plan, deductible, coinsurance, and optional benefit(s) desired.
Submit this with your Application. Availability is subject to Underwriting approval.

Proposed Insured (Print): _____ Date: _____

❑ Unlimited Access Plan

Any Doctor / Any Hospital

Deductible

❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000

Optional Benefits

❑ Maternity Benefit
❑ Dental Benefit
❑ AD&D
❑ Enhanced Prescription Drug Card

❑ HealthSelect PPO Plan

Preferred Provider (PPO)

Deductible

❑ $1,000 ❑ $1,500 ❑ $2,500 ❑ $5,000

Optional Benefits

❑ Maternity Benefit
❑ Dental Benefit
❑ Enhanced Prescription Drug Card

❑ Preferred Value Plan

High Deductible (HDHP)

Deductible

❑ $1,500 ❑ $2,500 ❑ $5,000 ❑ $10,000

Optional Benefits

❑ Enhanced Prescription Drug Card

❑ Healthy Savings Plan

HSA-Qualified

Deductible

Individual	Family
❑ $1,500	❑ $2,500
❑ $2,500	❑ $5,000
❑ $3,750	❑ $7,500
❑ $5,000	

Optional Benefits

❑ Maternity Benefit

Coinsurance Options

❑ 100%
❑ 80/20 to allowable max. (Only available with $1,500 or $2,500 deductible)

Additional Options

Term Life Rider

(Not Available on Preferred Value Plan)

❑ Proposed Insured ❑ Insured's Spouse

Benefit	***Benefit***
❑ $10,000	❑ $10,000
❑ $20,000	❑ $20,000
❑ $30,000	❑ $30,000
❑ $40,000	❑ $40,000
❑ $50,000	❑ $50,000

Cancer Policy

❑ Individual Plan
❑ Single Parent Plan
❑ Family Plan

Benefit Amount

❑ $10,000 ❑ $40,000
❑ $20,000 ❑ $50,000
❑ $30,000

Disability Income Policy

Monthly Benefit: _____
(from $400 - $3,000)

Elimination Period: ❑ 7 Days ❑ 14 Days ❑ 30 Days ❑ 60 Days* ❑ 90 Days* *(5 year plan only)

Benefit Period: ❑ 6 Months ❑ 12 Months ❑ 24 Months ❑ 60 Months* *(only available to P Class)

Occupation Class: ❑ Professional (P) ❑ Accidental (A) ❑ Manual Labor (B)

*Billing Fees: ___ Annual $0 ___ Semi-Annual $10 ___ Quarterly $10 ___ Monthly Direct $10
___ Credit Card $10 ___ PAC $2 ___ Convenience Bill $10

$ _____	$ **25**	$ _____	$ _____
Modal Premium	+ Application Fee	+ *Billing Fee	= Total Remitted

Please submit the premium, billing fee, and non-refundable application fee with your application. Make check payable to United Security Life & Health.

APPLICATION FOR INSURANCE

UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY
6640 S. Cicero Avenue
Bedford Park, IL 60638 • 800/875-4422

❑ **NEW INSURANCE**
Requested Effective Date (1st thru 28th only) _____
Month Day

❑ **ADD ON APPLICATION**

PROPOSED INSURED(S)
(Please include Maiden name) (First, MI, Last)

	Social Security #	Sex	Date of Birth	Age	State of Birth	Marital Status	Height	Weight	Tobacco Use
1. Primary Insured ❑ **Uninsured Applicant**									❑ YES ❑ NO
2. Spouse									❑ YES ❑ NO
3. Dependents									Full Time Student
A. _____									❑ YES ❑ NO
B. _____									❑ YES ❑ NO
C. _____									❑ YES ❑ NO
D. _____									❑ YES ❑ NO
E. _____									❑ YES ❑ NO

❑ YES ❑ NO If No, explain below. The parent where Dependent(s) reside must also sign this application.

_____

4. Residence Address

_____
Street City State Zip

_____/_____
Day Time Phone Number Cell Number Best Time to Call E-mail address

5. Billing Address (if different than above)

_____
Street City State Zip Phone Number

6. Occupation

_____ _____
Primary Insured – Employer Name Spouse – Employer Name

_____ _____
Duties Monthly Earned Income Duties Monthly Earned Income

7. Beneficiary (if applying for Life Insurance) If none listed, Beneficiary will be the Estate of the Insured

Primary Insured: _____ _____
Primary Relation to Insured Contingent Relation to Insured

Spouse: _____ _____
Primary Relation to Insured Contingent Relation to Insured

8. Do you or any Proposed Insured have any health insurance coverage currently in force or pending? ..... ❑ YES ❑ NO
Name of Company _____ Type of Coverage _____

9. Is this plan of insurance intended to replace any insurance in force? ..... ❑ YES ❑ NO

10. Has any Proposed Insured ever participated in any of the following occupations/avocations/activities: Aviation, ATV Riding, Bungee Jumping, Crop Dusting, Hang Gliding, Horse Riding, Martial Arts (over age 15), Motorcycle/Motorbike Riding, Motorized Vehicle Racing, Mountain/Rock Climbing, Parachuting, Parasailing, Professional/Semi-professional/Collegiate Athletics, Rodeo Activities, SCUBA Diving, Skydiving? If YES, provide complete details in # 24. ..... ❑ YES ❑ NO

11. Have any of the Proposed Insureds ever had a driver's license suspended, revoked, been cited for driving while intoxicated, had two or more violations in the past two years or been licensed to operate a motorcycle? ..... ❑ YES ❑ NO

If YES, Proposed Insured: _____ Driver's License #: _____ State Issued: _____

Details: _____

12. Has every Proposed Insured been a legal resident of the United States for the past year? If NO, give details:..... ❑ YES ❑ NO

_____

_____

MEDICAL HISTORY (All health questions must be answered)

13. Is any family member (whether applying for coverage or not) currently pregnant, an expectant parent, or in the process of adopting a child?
IF YES, NO FAMILY MEMBER IS ELIGIBLE FOR COVERAGE, even if the pregnant individual is not applying for coverage. ❑ YES ❑ NO

14. Has any Proposed Insured ever been told by a medical professional that they have, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or tested positive for HIV or HTLV III? ❑ YES ❑ NO

15. Has any Proposed Insured had any symptoms, testing, treatment, diagnosis, been prescribed medication for or had a consultation with a medical professional for any of the following physical systems, organs, illnesses, injuries, diseases, or disorders? **– Check all that apply.**

15A. Respiratory System ❑ YES ❑ NO
If YES, Check all that apply
❑ Allergies ❑ Asthma ❑ Bronchitis ❑ Emphysema/COPD ❑ Pneumonia ❑ Sinusitis
❑ Chronic Cough ❑ Tuberculosis ❑ Shortness of Breath ❑ Sleep Apnea ❑ Other Lung Disorder

15B. Circulatory System ❑ YES ❑ NO
If YES, Check all that apply
❑ Heart Disease ❑ Coronary Artery Disease ❑ High Blood Pressure ❑ Elevated Cholesterol/Triglycerides
❑ Varicose Veins ❑ Irregular Heartbeat ❑ Chest Pain ❑ Heart Murmur
❑ Stroke/TIA ❑ Phlebitis ❑ Blood Clot ❑ Blood Disorder ❑ Poor Circulation

15C. Digestive System ❑ YES ❑ NO
If YES, Check all that apply
❑ Ulcers ❑ Gastritis ❑ Colitis ❑ Stomach ❑ Gallbladder/Gall Stones
❑ Hernia ❑ Hemorrhoids ❑ Spleen ❑ Bleeding ❑ Esophagus/Reflux/GERD
❑ Pancreas ❑ Liver/Bile Ducts ❑ Hepatitis (A ___, B ___, C ___) ❑ Intestinal Disorder

15D. Endocrine System ❑ YES ❑ NO
If YES, Check all that apply
❑ Pancreas ❑ Diabetes ❑ Abnormal Blood Glucose ❑ Pituitary ❑ Other Gland Disorder
❑ Thyroid ❑ Goiter ❑ Addison's Disease ❑ Sugar in the Urine

15E. Reproductive System (Male/Female) ❑ YES ❑ NO
If YES, Check all that apply
❑ Ovaries/Ovarian Cyst ❑ Caesarean Section ❑ Miscarriage ❑ Menstrual Disorder
❑ Infertility ❑ Cervix ❑ Abnormal PAP ❑ Herpes
❑ Endometriosis ❑ Uterus/Uterine Fibroids ❑ Genital Warts ❑ Prostate/Elevated PSA ❑ Sexually Transmitted Diseases

15F. Urinary System ❑ YES ❑ NO
If YES, Check all that apply
❑ Kidney Stone/Disorder ❑ Bladder Stones ❑ Bladder ❑ Prostate ❑ Urinary Tract Infection

15G. Musculo-Skeletal System ❑ YES ❑ NO
If YES, Check all that apply
❑ Back/Spine/Vertebrae ❑ Fibromyalgia ❑ Arthritis ❑ Rheumatism ❑ Gout
❑ Foot/Knee Disorder ❑ TMJ/Jaw Disorder ❑ Lupus ❑ Herniated/Slipped Disc
❑ Arm/Shoulder Disorder ❑ Joint Disorder/Replacement ❑ Bursitis ❑ Collagen Vascular Disorder
❑ Connective Tissue Disorder ❑ Muscle/Ligament/Tendon/Cartilage Disorder ❑ Spinal Manipulation/Adjustment

15H. Nervous System ❑ YES ❑ NO
If YES, Check all that apply
❑ Epilepsy ❑ Convulsions ❑ Seizures ❑ Paralysis ❑ Parkinson's Disease
❑ Head Injury ❑ Brain Disorder ❑ Dementia ❑ Headaches/Migraines ❑ Alzheimer's Disease ❑ Neuropathy

15I. Mental/Nervous System ❑ YES ❑ NO
If YES, Check all that apply
❑ Anxiety/Depression ❑ Attention Deficit/ADD/ADHD ❑ Neurosis/Psychosis ❑ Sleep Disorder
❑ Bi-Polar Disorder ❑ Chemical Imbalance ❑ Psychiatric Treatment or Counseling ❑ Eating Disorder

16. Has any Proposed Insured had any symptom, consulted with, received medical care or advice from, been diagnosed or treated, had surgery for or received any prescription medication from any member of the medical profession for any condition or illness not listed above? ❑ YES ❑ NO

17. Has any Proposed Insured received treatment for cancer, melanoma, leukemia, tumor/growth, skin cancer, or cyst? ❑ YES ❑ NO

18. Has any Proposed Insured, in the past five years, taken any prescription medication or received any medical treatment? ❑ YES ❑ NO

19. Has any Proposed Insured been advised by a medical professional to have surgery, treatment, testing or hospitalization and not done so? ❑ YES ❑ NO

20. Has any Proposed Insured had any diagnosis related to, received treatment for, been advised to seek treatment, been told to decrease or discontinue alcohol consumption, used illegal drugs, or been hospitalized due to alcohol or drug use/abuse? ❑ YES ❑ NO

21. Has any Proposed Insured used, or is currently using, any tobacco products? ❑ YES ❑ NO

If YES, but not currently using, date last used: _____

22. Has any Proposed Insured experienced a weight change of more than 10% of his/her current weight in the past year? ❑ YES ❑ NO

23. Does any Proposed Insured currently have any internal fixations (i.e. screws, plates) or implants of any kind? ❑ YES ❑ NO

PROPOSED INSURED: _____

24. PROVIDE DETAILS FOR Questions #10 through #23. All columns must be fully completed and answered.

Question Number	Proposed Insured	Physician/Hospital	Treated Condition	Treatment/ Medication	Onset Date	Degree of Recovery

Primary Care Physicians (required for each applicant)

Proposed Insured _____ _____

Doctor's Complete Name — Last Visit-Date/Reason/Result

_____ _____

Address — City — State — Zip — Phone Number

Spouse (if applying) _____ _____

Doctor's Complete Name — Last Visit-Date/Reason/Result

_____ _____

Address — City — State — Zip — Phone Number

Dependent Child _____ _____

Doctor's Complete Name — Last Visit-Date/Reason/Result

_____ _____

Address — City — State — Zip — Phone Number

Dependent Child _____ _____

Doctor's Complete Name — Last Visit-Date/Reason/Result

_____ _____

Address — City — State — Zip — Phone Number

Dependent Child _____ _____

Doctor's Complete Name — Last Visit-Date/Reason/Result

_____ _____

Address — City — State — Zip — Phone Number

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company (USL&H) for insurance under the policy issued to the Apex Benefit Care Insurance Trust. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, USL&H's only obligation will be to return any premium paid; and, (c) that USL&H will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from USL&H and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information.) I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to USL&H, P.O. Box 388342, Chicago, Illinois 60638. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original. Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. 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 may be guilty of a crime and may be subject to fines and confinement in prison. **Disclaimer** — If premiums are paid from your employer's account, it is understood that: 1. USL&H assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor, will be fulfilled by the employer, as his own legal counsel may determine. 2. The policy is not guaranteed issue and will be fully underwritten by the Company which may result in the exclusion from coverage of certain family members (if applicable) and health conditions. USL&H assumes no responsibility for collection of premiums and/or the failure of your employer to remit them on a timely basis.

Dated at _____ _____
City **State** **Zip** **Date**

_____ _____
Applicant's Signature **Spouse's Signature (if to be covered)**

_____ _____
Dependent's Signature (If 18 or older) **Dependent's Signature (If 18 or older)**

_____ _____
Guardian/Representative's Signature/Relationship to Applicant **Dependent's Signature (If 18 or older)**

Agent Information: _____ _____ _____
Printed Name **Address** **Phone #**

I have truly and accurately recorded the information personally supplied by the applicant. Further, I have made no representations to the applicant other than those contained in the sales brochure.

_____ _____ _____ _____
Agent # **Signature** **E-Mail** **General Agent**

Method of Payment: ❑ Annual ❑ Semi-Annual ❑ Quarterly Direct ❑ Monthly Direct ❑ PAC ❑ Credit Card ❑ List Bill

Credit Card Number: _____ ❑ Visa ❑ MC ❑ Discover Exp. Date: _____

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

_____ _____
Bank Name **Bank Address**

As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life and Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

_____ _____ _____
Printed Name of Depositor **Signature of Depositor** **Date**

(PLEASE TURN OVER TO FINISH APPLICATION)

If you answered "YES" to question #9, you must complete this section.

Notice To Applicant Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a Certificate to be issued by United Security Life and Health Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new Certificate.

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

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

3. If, after due consideration, you still wish to terminate your present coverage 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 CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFICATE HAS 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**

AGENT CHECKLIST

By taking the time to check off the questions below, you are helping to ensure that your application has been filled out completely; allowing us to process the application quickly and accurately.

- ❑ Have you answered EVERY health question? (Make sure to check "Yes" or "No" for all sections of Question #15. If the answer is "Yes", please check all conditions that apply).
- ❑ Is the physician information complete with name, address AND phone number?
- ❑ Have you attached detailed descriptions for any health questions which have been answered "YES"?
- ❑ Has the applicant signed AND dated the application?
- ❑ Have you filled out the Agent Information section, complete with your signature, agent number and current e-mail address?
- ❑ Have you included payment or credit card information with the application?
- ❑ If the applicant is intending to replace current coverage have they signed the above Notice to Applicant Regarding Replacement of Health Insurance?
- ❑ Have you completed the Conditional Receipt Form?
- ❑ Have you separated and delivered the tear-off page (which includes the MIB, Inc. Pre-Notice, Investigative Consumer Report Notice, Abbreviated Notice of Information Practices, Conditional Receipt and Notice To Applicant Regarding Replacement of Health Insurance) to applicant?

Thank you for submitting your business to USL&H.
Did you know you can now submit applications electronically at www.unitedsecuritylandh.com?

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. However, United Security Life & Health Insurance Company may make a brief report to the MIB, Inc., a non-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with information it has in its file. Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information address is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, (617) 426-3660. The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.

Investigative Consumer Report Notice

Thank you for your application. As part of our underwriting procedure, a routine investigative consumer report may be made during the next few days. This report typically concerns information on an applicant's character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. We will be pleased to provide you with further information on the nature and scope of such a report, if one is made, upon receipt of your written request. You may request to be interviewed in connection with the preparation of such a report, and you are entitled to receive a copy of the report. Should you wish to contact us about questions you may have, please write to: United Security Life & Health Insurance Company, Life Administration Division, 6640 S. Cicero Avenue, Bedford Park, IL 60638.

Abbreviated Notice Of Information Practices

As permitted by law, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that: 1) Personal information may be collected from persons other than the individual or individuals proposed for coverage, 2) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization, 3) You have the right to access the information and correct it, 4) Your right of access does not include any information which relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding, 5) A more detailed notice of Insurance Information Practices will be furnished to the applicant or policyholder upon request.

TEAR OFF AND LEAVE WITH APPLICANT

Conditional Receipt - To be completed by agent.

Proposed Insured: _____ Date of Application: _____ Amount Received: _____ Date of Receipt _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO AGENT IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by USL&H at its Home Office.
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on the first presentation for payment. "An effective date in compliance with USL&H guidelines" means the latter of:
   a. The requested coverage date, if any, shown on the application; or
   b. The date upon which the application is approved by USL&H at its Home Office.
3. The policy is issued by USL&H exactly as applied for within 60 days from the date of application, delivered, and accepted by the proposed insured.

Limitation: This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. USL&H has the right to deny this application and, if it does so, the applicant will be notified in writing and the premium submitted (minus the application fee) will be refunded.

_____	_____	_____
Signature of Secretary	**Agent's Signature**	**Agent #**

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO UNITED SECURITY LIFE & HEALTH INSURANCE COMPANY.
DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from USL&H regarding the proposed insurance within 30 days, please call (800) 875-4422.

THIS FORM LIMITS OUR LIABILITY. BE SURE TO READ AND SIGN THE APPLICATION.
KEEP THIS DOCUMENT, IT HAS IMPORTANT INFORMATION.

As signed off on application

Notice To Applicant Regarding Replacement of Health Insurance

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a Certificate to be issued by United Security Life and Health Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new Certificate.

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

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

3. If, after due consideration, you still wish to terminate your present coverage 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 CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFICATE HAS 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.

Short Term Major Medical

The Perfect Solution if You Are:

- A Recent College Graduate
- Temporarily Unemployed
- A Temporary or Seasonal Worker
- Retiree Waiting for Medicare Coverage
- Waiting For Coverage from Your Employer
- Recently Discharged from the Military
- Applying for Major Medical Coverage with USL&H

Plan Highlights

- Coverage Available as Early as Next Day
- $2 Million Lifetime Maximum
- Visit Any Doctor/Any Hospital
- Prescription Drug Coverage
- Limited Benefits While Outside the U.S.

*Apply Online at **www.unitedsecuritylandh.com** and We'll Waive the $25 Application Fee!*

Other Health Care Products from United Security Life and Health

If you are approved for a Major Medical plan with USL&H, you may also be pre-approved for our ancillary products:

E-Z Life (Simplified-Issue)

Piece of mind for your final expenses

- Face Amounts from $2,500 - $25,000
- Whole Life Policy
- Simplified Underwriting – Only 7 health questions!
- Optional Accelerated Death Benefit

Disability Income

It works when you can't

- Monthly Benefits from $400 - $3,000
- 24-Hour Coverage – On or off the job!
- No Restrictions on How to Use Benefit Money

Cancer Benefit

Provides a benefit as soon as you need it… for whatever you need

- Guaranteed Renewable for Life
- Lump Sum Benefit up to $50,000 Available
- Benefit Paid Upon Diagnosis - No restrictions on how you use the money!

USLH UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY

www.unitedsecuritylandh.com

6640 SOUTH CICERO AVENUE, BEDFORD PARK, ILLINOIS 60638 • 800/875-4422

APP10/08