Save…Time and Money

Pre-authorized Bank Check Plan or Electronic Transfer are the convenient ways to pay your premiums. Payments are always on time with no unintentional lapses of your valuable protection. You have no checks to make out, no postage stamps to bother with, no premium notices to return, and less cost in billing fees.

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE INSURANCE COMPANY OF ILLINOIS

Name of Bank: _____

Address of Bank: _____

_____

As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life Insurance Company of Illinois, 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

If Bank Check Plan or Electronic Transfer
ATTACH VOIDED CHECK HERE
and Sign Authorization Above

Application for

First Benefit Cancer Insurance

Application For Cancer Insurance

UNITED SECURITY
LIFE INSURANCE COMPANY
OF ILLINOIS

10275 WEST HIGGINS ROAD • ROSEMONT, ILLINOIS 60018
847/298-1400 • 800/875-4422

PLEASE TYPE OR PRINT

1. List each person to be insured

(First, Middle Initial, Last Name)	Social Security No.	Marital Status	Birth Date	Age Last Birthday	Sex	Height	Weight
A. Proposed Insured							
B. Spouse							
Dependent Children C.							
D.							
E.							

2. Residence of proposed insured

_____ Home Phone Number (_____) _____

Street Number, City State Zip Code

Billing Address (Leave blank if same as above) _____

3. Has any person to be insured been diagnosed as having, or received treatment during the last two years for cancer of the skin? ☐ Yes ☐ No

If yes, name of person(s):_____

4. Has any person to be insured ever been diagnosed as having, or received treatment during the last ten years for Internal Cancer, Leukemia, Hodgkin's Disease, or Melanoma? ☐ Yes ☐ No

If yes, name of person(s):_____

5. Has any person to be insured been advised (by a member of the medical profession) to have any diagnostic tests related to cancer which have not been performed or for which you have not received results? ☐ Yes ☐ No

6. Has any person to be insured ever been diagnosed as having, or ever received treatment for Acquired Immune Deficiency Syndrome (AIDS) or ever tested positive for the Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If yes, name of person(s): _____

7. Is this Policy intended to replace any existing Policy in this or any other Company? ☐ Yes ☐ No

If yes, list Company name and Policy number:_____

8. Benefit selected: ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

9. Type of Plan selected: ☐ Individual ☐ Single Parent ☐ Family

10. Premium Payment Mode: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Bank Draft/EFT—monthly

Insured's Statement and Authorization To Release Medical Information

I hereby apply to United Security Life Insurance Company of Illinois for a policy to be issued in reliance on my written answers to the aforegoing questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an Outline of Coverage for the policy applied for.

The undersigned Agent certifies that the Applicant has read, or had read to him, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I authorize any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to the United Security Life Insurance Company of Illinois for the purpose of determining my eligibility for insurance and the eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a photostat of this authorization is to be acceptable. This authorization will remain in effect for a period of 30 months from the date signed. I understand that I, or my authorized representative, may request a copy of this authorization.

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied for to the Applicant.

X _____
Agent's Signature Agent No.

Agent's Address: _____

Dated at _____ 19____
(city and state) (month) (day) (year)

Mail Policy to: ☐ Applicant ☐ Agent Agent's Phone:_____

I understand that no benefits are payable for a diagnosis of cancer in the first 30 days after the effective date of this policy. I also understand that no person covered by this policy is also covered by a Title XIX program, Medicaid or any other similar name. This does not apply to residents of Arizona.

X _____
Applicant's Signature

Amount paid to Agent: $_____ for first _____ months premium.