

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: _____

PROTECTOR PLUS
Preferred Provider Plan
Deductible
 \$500 \$2,500
 \$1,000 \$5,000
 \$1,500 \$10,000

Coinsurance Options
 (For Deductibles less than \$10,000)
 80/20 to \$10,000
 80/20 to \$5,000

Lifetime Maximum
 \$2,000,000 \$5,000,000

<i>Optional Benefits</i>	YES	NO
Network Physician Copay	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Copay Card	<input type="checkbox"/>	<input type="checkbox"/>
Maternity	<input type="checkbox"/>	<input type="checkbox"/>
Accident (\$500)	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>

ADVANTAGE CARE
HSA Qualified/PPO Plan
Deductible
Individual *Family*
 \$1,500 \$2,500
 \$2,500 \$5,000
 \$3,750 \$7,500
 \$5,000 \$10,000

Lifetime Maximum
 \$2,000,000 \$5,000,000

<i>Optional Benefits</i>	YES	NO
Maternity	<input type="checkbox"/>	<input type="checkbox"/>

APEX BENEFIT CARE
Any Doctor/Any Hospital
Deductible
 \$250 \$2,500
 \$500 \$5,000
 \$1,000

Coinsurance Options
 80/20 to \$5,000
 50/50 to \$2,000 (Rate Reducer)

Lifetime Maximum
 \$2,000,000 \$5,000,000

<i>Optional Benefits</i>	YES	NO
Accident/AD&D	<input type="checkbox"/>	<input type="checkbox"/>
Maternity	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>

OPTIONAL COVERAGES

TERM LIFE INSURANCE RIDER

Proposed Insured **YES** **NO**

Face Amount
 10,000 20,000 30,000
 40,000 50,000

Spouse **YES** **NO**

Face Amount
 10,000 20,000 30,000
 40,000 50,000

FIRST BENEFIT CANCER POLICY

Individual Plan
 Single Parent Plan
 Family Plan

Benefit Amount
 \$10,000
 \$20,000
 \$30,000
 \$40,000
 \$50,000

INCOME SECURITY POLICY

Proposed Insured: _____

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

Elimination Period: 7 Days 60 Days*
 14 Days 90 Days*
 30 Days
 * 5 year Plan only

Benefit Period: 6 Months 24 Months
 12 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** + \$ _____ + \$ _____ = **Total Remitted**

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



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

NEW INSURANCE

Requested Effective Date (1st thru 28th only) _____

ADD ON APPLICATION

Month _____ Day _____

PROPOSED INSURED(S)

(First, MI, Last)

	Social Security #	Sex	Date of Birth	Age	State of Birth	Marital Status	Height	Weight	Tobacco Use
1. Primary Insured <input type="checkbox"/> Uninsured Applicant									<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Spouse									<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Dependents									Full Time Student <input type="checkbox"/> YES <input type="checkbox"/> NO
A. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
B. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
C. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
D. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO
E. _____									<input type="checkbox"/> YES <input type="checkbox"/> NO

Do all Dependents live with the Primary Insured? 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
 Allergies Asthma Bronchitis Emphysema/COPD Pneumonia Sinusitis
 Chronic Cough Tuberculosis Shortness of Breath Sleep Apnea Other Lung Disorder
If YES, Check all that apply
- 15B. Circulatory System** YES NO
 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
If YES, Check all that apply
- 15C. Digestive System** YES NO
 Ulcers Gastritis Colitis Stomach Gallbladder/Gall Stones
 Hernia Hemorrhoids Spleen Bleeding Esophagus/Reflux/GERD
 Pancreas Liver/Bile Ducts Hepatitis (A ____, B ____, C ____) Intestinal Disorder
If YES, Check all that apply
- 15D. Endocrine System** YES NO
 Pancreas Diabetes Abnormal Blood Glucose Pituitary Other Gland Disorder
 Thyroid Goiter Addison's Disease Sugar in the Urine
If YES, Check all that apply
- 15E. Reproductive System (Male/Female)** YES NO
 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
If YES, Check all that apply
- 15F. Urinary System** YES NO
 Kidney Stone/Disorder Bladder Stones Bladder Prostate Urinary Tract Infection
If YES, Check all that apply
- 15G. Musculo-Skeletal System** YES NO
 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
If YES, Check all that apply
- 15H. Nervous System** YES NO
 Epilepsy Convulsions Seizures Paralysis Parkinson's Disease
 Head Injury Brain Disorder Dementia Headaches/Migraines Alzheimer's Disease Neuropathy
If YES, Check all that apply
- 15I. Mental/Nervous System** YES NO
 Anxiety/Depression Attention Deficit/ADD/ADHD Neurosis/Psychosis Sleep Disorder
 Bi-Polar Disorder Chemical Imbalance Psychiatric Treatment or Counseling Eating Disorder
If YES, Check all that apply
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

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.

- | | |
|--|---|
| <input type="checkbox"/> 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). | <input type="checkbox"/> Have you included payment or credit card information with the application? |
| <input type="checkbox"/> Is the physician information complete with name, address AND phone number? | <input type="checkbox"/> If the applicant is intending to replace current coverage have they signed the above Notice to Applicant Regarding Replacement of Health Insurance? |
| <input type="checkbox"/> Have you attached detailed descriptions for any health questions which have been answered "YES"? | <input type="checkbox"/> Have you completed the Conditional Receipt Form? |
| <input type="checkbox"/> Has the applicant signed AND dated the application? | <input type="checkbox"/> 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? |
| <input type="checkbox"/> Have you filled out the Agent Information section, complete with your signature, agent number and current e-mail address? | |

Thank you for submitting your business to USL&H.

Did you know you can now submit applications electronically at www.unitedsecuritylandh.com?

Did You Know?

USL&H Offers More Than Health Insurance!

E-Z Life

- Final Expenses
- Simplified Issue Up To \$25,000
- No Exams Or Records
- Ages 0-85

Disability Income

- Short Waiting Periods
- Benefits Up To 5 Years
- Coverage Available for Most Occupations

ASK YOUR AGENT ABOUT OUR TERM LIFE RIDER

Coverage up to \$50,000

For rates as low as \$2 per month, you can increase your protection with USL&H Term Life Insurance.

The rates below reflect the monthly premium rates for Term Life coverage depending on applicant age and face amount. These rates are guaranteed if the health policy is issued. To apply for Term Life coverage, check “Yes” and indicate your desired Face Amount on the Benefit Selection Sheet.

AGE	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Under 30	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00
30-39	\$2.30	\$4.60	\$6.90	\$9.20	\$11.50
40-44	\$3.80	\$7.60	\$11.40	\$15.20	\$19.00
45-49	\$6.30	\$12.60	\$18.90	\$25.20	\$31.50
50-54	\$8.70	\$17.40	\$26.10	\$34.80	\$43.50
55-59	\$14.20	\$28.40	\$42.60	\$56.80	\$71.00
60-64	\$18.30	\$36.60	\$54.90	\$73.20	\$91.50



www.unitedsecuritylifeandhealth.com

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