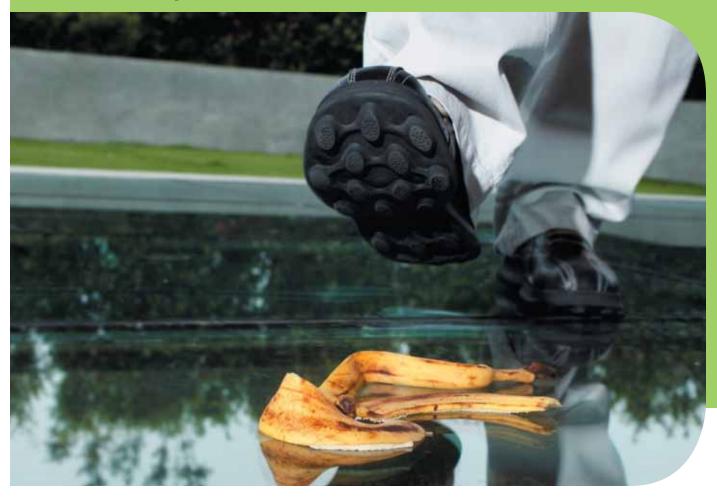
Hospital Cash Plan



No one plans to get sick or injured. Be prepared if it happens to you.



Humana Financial Protection Products

Hospital Cash Plan



Protect your savings from unexpected expenses.

In recent years, more than 40% of Americans have made an unexpected visit to an emergency room.* Your hard-earned savings could be at risk because of an accident or illness you have no way of predicting or preventing. Humana's **Hospital Cash Plan** is insurance that pays cash to you, or your designee, when you're sick or injured and need medical attention. Cash that can help pay for things your other insurance plans may not cover like copayments, deductibles, transportation expenses, and more ... the choices are endless.

Even if you already have insurance, this plan pays you cash for:

- Emergency room treatment for accidental injury or sickness
- ✔ Benefits for hospital confinement and outpatient surgery

Base benefits

Lump Sum	for Hospita	al Confineme	nt – Five Poli	cy Options			
\$250	\$500	\$1,000	\$1,500	\$2,000			
Maximum o	Maximum of one confinement for each insured per year						
Lump Sum	for Accider	ntal Injury an	d Sickness				
\$150 for ea Emergency	\$150 for each Within 72 hours of an accidental injury						
Maximum payments per year • Individual – 2 • Single Parent – 4 • Family – 6							
Lump Sum	Lump Sum for Outpatient Surgery						
\$150 for each Outpatient Surgery							
Paid per admittance/visit. For multiple surgeries within one admittance/visit, policy provides one cash payment.							
 Maximum payments per year Individual – 2 Single Parent – 4 Family – 6 							

Optional benefits

Hospital Indemnity/ICU Daily Benefit Rider – Three Policy Options
• \$50/day (\$200/day if ICU)

- •\$100/day (\$400/day if ICU)
- •\$200/day (\$800/day if ICU)

Maximum of 30 days during a period of confinement resulting from injury or sickness, under the supervision of a physician, and beginning while rider is in force

Paid day one along with the lump-sum hospital confinement benefit

One period of confinement means one continuous hospital confinement or two or more hospital confinements for the same or related injury or sickness.

All hospital confinements due to the same or related cause or causes shall be considered one and the same confinement unless periods of confinement resulting there from are separated by an interval of at least 180 consecutive days between the end of one such confinement and the beginning of a subsequent such confinement.

Policy limitations Covers certain pre-existing conditions after a 12-month waiting period. Waiting periods apply to certain conditions, see policy form for details.

Hospital Cash Plan is Kanawha Insurance Company policy Form 90840 LA and optional rider policy Form 90841 LA. Limitations and exclusions apply. The benefits and riders offered are supplemental and not intended to cover all medical expenses. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.



* U.S. Department of Health and Human Services, Advance Data, June, 2007.

Application for Hospital Indemnity Kanawha Insurance Company



SE INDICATE: O NEW COVERAGE O CHANGE TO EXISTING COVERAGE O CONVERS	SION
First Name MI Last Name Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Address (Street or R.R.) -	Suffix Gender O Male O Female
Spouse Name (First Name, MI, Last Name) (If proposed for coverage) Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Image: A structure of the str	Suffix Gender Male • Female
Child Name (First Name, MI, Last Name) (If proposed for coverage) Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number / / - - - -	Suffix Gender Male • Female
Child Name (First Name, MI, Last Name) (If proposed for coverage) Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number - -	Suffix Gender Male O Female
Child Name (First Name, MI, Last Name) (If proposed for coverage) Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number Image: An image of the security of the secure secure security of the security of the security of t	Suffix Gender Male • Female
	n(s) Proposed for Coverage First Name MI Last Name Birthdate (MM/DD/YYYY) Height (Ft-In) Weight Social Security Number / / / / / / / / / / / / / / / / / / /

210 South White Street, Lancaster SC 29720 Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-207-0158 Kanawha Insurance Company is a member of the Humana family of companies.

BENEFIT SECTION									
Plan Type O Individual (adult or child) O Family (2 parents and all children) O S	Single	Pare	ent (pare	ent a	and	all c	hildr	·en)
Base Benefit ○ \$250 ○ \$500 ○ \$1,000 ○ \$1,500 ○ \$2,000	•			•					
				••	-	-			
Optional Benefit: Hospital Confinement Daily Benefit Rider/Intensive Care	-) Da	ally	Ben	eti	C		
○ \$50/day (\$200/day if ICU) ○ \$100/day (\$400/day if ICU) ○ \$200/day (\$800/da	ay if IC	CU)							
Payment Method O Bank Draft O Credit Card O Direct Bill/Check (Annual Billin	g Only	')							
(Complete Bank Draft or Credit Card Authorization. Annual fee of	\$12.00) ap	plies	s to d	cred	it ca	ard ł	oillin	ıg.)
Payment Mode Monthly Semi-annual Annual Total Modal Prem	ium	¢		Τ	1Г	Τ	٦		
	iuiii	Ψ			ĿL				
APPLICANT'S REPRESENTATION AND AGREEMENT (Louisiana law prohibits genetic testing or questions related to genetic information fro companies as a condition of obtaining health insurance coverage.)	m bei	ng u	sed	by ł	nealt	:h in	ısura	ance	
1. Has anyone proposed for coverage ever been diagnosed or treated by a member of	Drin	nary							
the medical profession as having:		ured	Spo	ouse	Chil	d 1 (Child	2 C	hild 3
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC),	Yes	s/No	Yes	/No	Yes/	'No	Yes/I	No Y	'es/No
or tested positive to the antibodies for Human Immunodeficiency Virus (HIV)	0	0	0	0	0	0	0	00	0 0
b. Alzheimer's Disease	0		0			-		0	0 0
c. Senile dementia		0	0	0	0	0	0	0	0 0
d. Uncorrected congenital heart defect (excluding mitral valve prolapse)		<u> </u>	0	_	0	_			0 0
e. Kidney disease (not including kidney stones)	_		0	_			0		0 0
f. Systemic lupus			0	_		_	0	_	0 0
g. Insulin-dependent diabetesh. Liver disease or disorder (excluding Hepatitis A)		-	0	0		_	0	_	0 0
2. a. Is any person proposed for coverage currently confined in a hospital, nursing	0	0	0	0	0	0	0	0	0 0
home, or any medical facility?	0	0		0	0		0		\sim
b. Has a member of the medical profession recommended hospitalization, surgery,		U				\sim	\mathbf{O}		
or nursing home confinement that has not yet occurred?	0	0	0	0	0	0	0	\circ	\circ
3. Within the last 5 years has any person proposed for coverage been diagnosed or									
treated by a member of the medical profession for internal cancer (except basal cell									
cancer)?		0	0	0	0	0	0	0	0 0
seen in an emergency room by a member of the medical profession for:									
a. Angioplasty, stent placement, heart surgery		0		0	0		0		0 0
b. Angina (heart related chest pain), heart attack, hypertension, congestive heart		Ŭ		Ŭ		\sim	0		
failure, peripheral vascular disease (circulatory problems)		0	0	0	0	0	0	0	0 0
c. Emphysema, chronic lung disease, asthma	0	0	0	0	00	0	0	0	0 0
d. Cerebral vascular accident (CVA, stroke), cerebral vascular insufficiency,									
transient ischemic attack (TIA, ministroke) e. Type II diabetes		0	0	0	0	0	0	0	0 0
f. Parkinson's Disease	\sim	0			0		0		0 0
g. Crohn's Disease, ulcerative colitis		0		0	000				
h. Sickle cell anemia	\sim	0		0	0			_	
i. Transplants		0		0	0				$\frac{1}{2}$
		<u> </u>		-		_		<u> </u>	/
5. Does any person proposed for coverage have any other Hospital Indemnity coverage	in for	ce oi	r an	app	licat	ion			
for similar insurance pending with this or any other company?) Ye	s	O No
If "YES", please provide details with specific benefit amounts below.								-	
						_			
 Will the policy applied for replace any coverage currently in force? If "YES", please complete the following. 		•••••	•••••	•••••		C) Ye	S	O No
Company Person Covered Policy Number									

\square	Payor Information (First, MI, Last Name) (If different than the Proposed Insured) Suffi	x
E		
Information	Social Security Number	
orm		
ľuť	Address (Street or R.R.)	
Payor]		
Pa	City State ZIP Code	

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.

I have read or had read to me all the questions on this Application and I represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the time limit on certain defenses or incontestability provisions of the policy. I understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

I acknowledge, if required in my state, that I have been furnished:

Ε	Outline of Cove	erage 🛛 Medicar	e Buyer's G	Guide (If age	e 65 or over)		
Signed At	City	[itate	F		1	_
Signat	ure of Primary In	surod/Ownor				/	
		d only coverage)		Da	ate (MM/DD/Y	YYY)	
	FOR IN	ISURANCE PRO	DUCER'S L	JSE ONLY			
I certify any information rec	orded by me on	this Application is	true and a	ccurate to th	ne best of my	knowledge and	belief.
Will this insurance replace a	ny existing insur	ance?				······ O Yes	O No
					Date (MM	/DD/YYYY)	
Signature of Licensed Insuranc	e Producer				/	/	
Printed Name of Licensed Insu	rance Producer _						
Insurance Producer Number	% Credit II	nsurance Producer	Number (% Credit	Insurance Pr	oducer Number	% Credit
							1
1664 A		Pag	e 3			8013562	342

	AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT							
ck	Name of Depositor (First, MI, Last Name) (Attach Voided Check) Suffix							
che								
0 p								
ide								
Voi	Route and Transit Number Account Number							
ch	Bank Name and Address							
Attach Voided Check								
Ā								
Del	it on the day of the month (1-28 only; 29, 30, 31 not available). If no election is made, debits will be							
	de on the day of Policy.							
	convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to make deductions automatically							
	y payment period for payments of premiums from my: O savings account O checking account Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is							
	selected, the day of Policy.							
	This Authorization shall not become effective unless and until the coverage is issued. This Authorization shall not be construed as modifying any provisions of the coverage.							
	Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time							
	stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.							
5.	This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days							
	prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable							
6.	annually. (anawha will notify me TEN (10) days prior to any changes in payment amounts.							
Sig								
<u> </u>	CREDIT CARD INFORMATION Credit Card Number Expiration Date (MM/YY)							
tion	Card Type							
ormation	Visa Mastercard							
	3 or 4-digit security code found on the back of most cards:							
ŗ								
lde	Signature of Card Holder Date (MM/DD/YYYY)							
Card Holder Inf	Name as it appears on the credit card statement (If different from Proposed Insured).							
ard	Card Holder (First Name, MI, Last Name) Suffix							
Ű								
	All charges will be made on the day of Policy. convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to charge my credit card every							
	convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to charge my credit card every ient period for payment of premiums.							
1. 1	ach charge shall constitute proper notice of premium due.							
	his Authorization shall not become effective unless and until the Policy is issued. his Authorization shall not be construed as modifying any provisions of the Policy.							
	anawha shall not incur any liability if the credit card company does not honor the charge and the Policy shall lapse							
	ubject to nonforfeiture provisions.							
	his Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) usiness days prior to the payment date. Upon termination of this Authorization, premiums for the Policy							
,	will be payable annually.							
6.	anawha will notify me TEN (10) days prior to any changes in payment amounts.							
\ Sign	iture of Card Holder Date (MM/DD/YYYY)							
16								