Memorial Fund

You can relax, knowing your final wishes will be respected.

HUMANA
Guidance when you need it most

Humana Financial Protection Products

GNA06XOHH 11/09 LA

Memorial Fund

Ensure financial peace of mind for you and your family.

You may have already planned ahead for funeral expenses. But there are so many costs your family could face, including medical bills, legal fees, taxes, and other expenses. Humana's **Memorial Fund** is whole life insurance that pays cash to your designee to take care of your final expenses and more.

The plan lets you relax knowing that:

- ✔ Your final arrangements can be carried out
- ✔ You'll avoid burdening your family with unexpected costs
- ✔ You're taking the future into your hands today

The **Memorial Fund** is whole life insurance that has guaranteed cash values. As the policy matures, cash value in the policy grows.

Memorial Fund Benefit Features

Individual coverage	
Policy benefits from $1,000 to $25,000 in $1,000 increments.	
Two Payment Methods	
Premiums are payable for the life of the policy or until death.	Pay premiums for 10 years (without lapse.) Coverage continues with no additional premiums required.

Memorial Graded Benefit Features

This benefit may be available to individuals who do not qualify for the Memorial Fund.

Year One	Year Two	Year Three	Year Four and Beyond
25% of face value	50% of face value	75% of face value	100% of face value

Memorial Fund is Kanawha Insurance Company policy Form 00800 1/88 and graded benefit policy Form 00020 3/90. Limitations and exclusions apply. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.

HUMANA®
Guidance when you need it most

Application for Memorial Fund Life Insurance

Kanawha Insurance Company

HUMANA
Guidance when you need it most

Proposed Insured (Please Print)

Proposed Insured (Print First Name, MI, Last Name) | Suffix

Date of Birth (MM/DD/YYYY) | Social Security Number | Age | Gender

- ○ Male
- ○ Female

Address (Street or R.R.)

City | State | ZIP Code | Home Telephone Number

Owner

(Complete if different from Proposed Insured)

Owner (Print First Name, MI, Last Name, if not Proposed Insured) | Suffix

Social Security Number

Address (Street or R.R.)

City | State | ZIP Code

Payor

(Complete if different from Proposed Insured)

Payor (Print First Name, MI, Last Name, if not Proposed Insured) | Suffix

Social Security Number

Address (Street or R.R.)

City | State | ZIP Code

Primary Beneficiaries' Name, SSN and Percentage: _____

Relationship:

- ○ Parent, Spouse, Child(ren)
- ○ Other: _____

Contingent Beneficiaries' Name, SSN and Percentage: _____

Relationship:

- ○ Parent, Spouse, Child(ren)
- ○ Other: _____

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.

Section A: If any question in this section is answered "Yes", the Proposed Insured is not eligible for any coverage.

	Proposed Insured
1. Have you ever been diagnosed or treated by a member of the medical profession as having a terminal illness, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	○ Yes ○ No
2. Are you currently:	
(a) Receiving hospice or home health care?	○ Yes ○ No
(b) Bedridden, confined to a hospital, nursing home, or other facility, or has confinement been recommended by a member of the medical profession?	○ Yes ○ No
3. Have you ever been diagnosed or treated by a member of the medical profession as having Alzheimer's disease or dementia?	○ Yes ○ No
4. In the past 12 months have you been diagnosed or treated by a member of the medical profession for internal cancer?	○ Yes ○ No

Section B: If any question in this section is answered "Yes", the Proposed Insured is eligible for the Graded Death Benefit Product. If all questions in this section are answered "No", the Proposed Insured is eligible for the Immediate Death Benefit Product.

5. Have you been diagnosed or treated by a member of the medical profession as having:	
(a) Diabetes before age 30, or suffered complications from diabetes such as neuropathy, retinopathy, kidney or vascular problems	○ Yes ○ No
(b) Emphysema, chronic obstructive pulmonary disease or a lung disorder requiring oxygen	○ Yes ○ No
(c) Heart attack, coronary artery disease diagnosed before age 60	○ Yes ○ No
(d) Heart valve disease requiring surgery	○ Yes ○ No
(e) Stroke, aneurysm or cardiomyopathy	○ Yes ○ No
(f) Kidney disease, liver disease or hepatitis C	○ Yes ○ No
(g) Multiple sclerosis or Parkinson's disease	○ Yes ○ No
6. Within the past 5 years have you been hospitalized, diagnosed or treated by a member of the medical profession as having:	
(a) Cancer, leukemia, melanoma or any other malignancy (except basal cell skin cancer)	○ Yes ○ No
(b) Mental or nervous disorder	○ Yes ○ No
7. Within the past 2 years, have you been treated or counseled by a member of the medical profession for alcoholism, alcohol abuse or any drug or substance abuse?	○ Yes ○ No

Section C:

8. (a) Do you have any other similar coverage in force or an Application for similar insurance pending with this or any other company?	○ Yes ○ No
(b) Will the insurance herein applied for replace any existing insurance with this company or any other company?	○ Yes ○ No
(If "Yes", list company, address, complete and submit replacement form.)	

BENEFIT SECTION

Benefit Amount $ ☐☐,☐☐☐ (sold in $1,000 increments up to a maximum of $25,000)

Plan Type ○ Immediate Death ○ Graded Death

Payment Period ○ Whole Life ○ 10 pay Whole Life

Payment Method ○ Bank Draft ○ Credit Card ○ Direct Bill/Check (Annual Billing Only)
(Complete Bank Draft or Credit Card Authorization. Annual fee of $12.00 applies to credit card billing.)

Payment Mode ○ Monthly ○ Semi-annual ○ Annual

Total Modal Premium $ ☐☐☐.☐☐

Is Automatic Premium Loan to apply? ○ Yes ○ No

Requested Effective Date (Optional) (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check

Name of Depositor (Print First Name, MI, Last Name) (Attach Voided Check)

Route and Transit Number

Account Number

Bank Name and Address

Debit on the ____ day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: ○ savings account ○ checking account

1. 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.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. 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 annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor _____ Date (MM/DD/YYYY) ____ / ____ / ____

CREDIT CARD INFORMATION

Card Holder Information

Credit Card Number

Expiration Date (MM/YY) ____ / ____

Card Type ○ Visa ○ Mastercard

3 or 4-digit security code found on the back of most cards: ____

Signature of Card Holder_____ Date (MM/DD/YYYY) ____ / ____ / ____

Name as it appears on the credit card statement. (If different from Proposed Insured)

Card Holder (First Name, MI, Last Name) Suffix

All charges will be made on the day of Policy.

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

1. Each charge shall constitute proper notice of premium due.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the 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 payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder_____ Date (MM/DD/YYYY) ____ / ____ / ____

AGREEMENTS

The statements and answers on this Application are true and complete to the best of my knowledge and belief.

It is agreed that:

(a) This Application, and any amendments hereto, shall be the basis of any insurance granted.
(b) No Insurance Producer has the authority to waive the answer to any question in this Application, to waive any of the Company's rights or requirements or to make or alter any contract; and
(c) No insurance shall be considered in force unless and until a policy shall have been issued by the Company and said policy manually received and accepted by the Proposed Insured and the full first premium paid thereon, all during the lifetime of the Proposed Insured.

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 subjected to fines and confinement in prison.

Signed At _____ City _____ State

_____ Signature of Proposed Insured

__ / __ / ____ Date (MM/DD/YYYY)

_____ Signature of Owner

INSURANCE PRODUCER'S USE ONLY

Does the applicant have any existing life insurance policies or annuity contracts?..... ○ Yes ○ No

Is this insurance being purchased to replace or change any existing insurance?..... ○ Yes ○ No
(If "Yes", complete replacement form.)

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Signature of Licensed Insurance Producer _____

Date (MM/DD/YYYY) __ / __ / ____

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit	Insurance Producer Number	% Credit