Philadelphia American Life Insurance Company

Cancer Supplemental Insurance

In this packet:
Application

Texas

Additional forms may be required, but not included in this packet

- **Outline of Coverage Form 292N TX**
- **Replacement Form 1987N**

Cancer Insurance
Application (Policy Form C36 TX)

H.O. USE ONLY

Section A: General Information

Applicant's Name (Print First, Middle, Last)	Sex	Birth Date	Social Security Number

Street Address	Telephone

City, State, Zip Code

Spouse's Name (If to be insured)	Sex	Birth Date

Children (Print First, Middle, Last)	Sex	Birth Date	Children (Print First, Middle, Last)	Sex	Birth Date
1.			4.		
2.			5.		
3.			6.		

I hereby apply for the following coverage: ☐ Individual ☐ Single Parent Family ☐ Family

Cancer Policy Form C36 TX
Hospital Confinement Benefit (Check one): ☐$150 per day ☐$250 per day ☐$350 per day

Benefit Riders:
Radiation Treatment, Chemotherapy, Hormone Therapy, Immunotherapy and Related Services Benefit Rider (Must check one):

☐Form 8305N
☐Form 8306N

Optional Benefit Riders:
Internal Cancer First Occurrence Benefit Rider Form 8288N (Check one): ☐$2,500 ☐$5,000

Hospital Intensive Care Confinement Benefit Rider Form 8290N TX with a Daily Benefit of (Check one): ☐$300 ☐$600

☐Specified Disease Benefit Rider Form 8311N TX

Billing Type: ☐**Worksite - Standard** ☐**Worksite - Other** ☐**Association** ______________________ (name)

☐ List Bill ☐ Pre-Authorized Check ☐ Direct Bill

Total premium $____________ ☐ Monthly* ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other_____________
*Monthly Direct Bill Not Available Make all checks payable to Philadelphia American Life Insurance Company.

Section B: Employment Information

Applicant's Occupation	Employment Date (mo/yr)	Do you work 20 hours or more a week at this occupation? .... ☐Yes ☐No

Section C: Medical Information

1a. **Skin Cancer** - Have you or any person to be insured been treated for or diagnosed with non-melanoma skin cancer in the last 2 years? .... ☐Yes ☐No
If "Yes", identify name(s) of person(s)________________________________

1b. **Cancer -** Have you or any person to be insured ever been treated for, diagnosed with or advised they may have internal cancer, carcinoma in situ, melanoma or any malignancy? .... ☐Yes ☐No
If "Yes", identify name(s) of person(s), list the name of condition and date of last treatment: ________

The person(s) named in questions 1a and 1b may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

2. Have you or any person to be insured ever been advised by a member of the medical profession to have any diagnostic tests related to cancer which have not been completed or for which results have not been received? .... ☐Yes ☐No
If "Yes", identify name(s) of person(s):________________________________

The person(s) named in question 2 will be excluded from coverage but may reapply once diagnostic tests have been completed and for which results have been received.

3. Have any persons to be insured within the last five years been treated for or been diagnosed by a member of the medical profession or currently have Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Antibodies to Human T-lymphotrophic Virus Type III (HTLV-III)? .... ☐Yes ☐No
If "Yes", identify name(s) of person(s):________________________________

Section C: Medical Information (cont'd)

Specified Disease Rider Form 8311N TX (complete questions 4 and 5 only if applying for Form 8311N TX)

4. Have you or any person to be insured ever been treated for, diagnosed with or advised they may have any of the following diseases: Addison's Disease, Budd-Chiari Syndrome, Cerebral Palsy, Cystic Fibrosis, Encephalitis, Huntington's Disease, Legionnaire's Disease, Lou Gehrig's Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Polio, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Tuberculosis, Whooping Cough? .... ☐Yes ☐No

   If "Yes", identify name(s) of person(s), list the name of condition and date of last treatment: _________

   ____

   The person(s) named in question 4 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

5. Have you or any person to be insured ever been advised by a member of the medical profession to have any diagnostic tests related to one of the specified diseases listed above which have not been completed or for which results have not been received? .... ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s):________________________________

   The person(s) named in question 5 will be excluded from coverage but may reapply once diagnostic tests have been completed and for which results have been received.

Hospital Intensive Care Rider Form 8290N TX (complete questions 6a & 6b only if applying for Form 8290N TX)

6a. Are you or any family member (applying or not applying for coverage) currently pregnant? .... ☐ Yes ☐ No

   If "Yes" to question 6a, Hospital Intensive Care Rider Form 8290N TX cannot be issued.

6b. Have you or any person to be insured ever been treated for or diagnosed with a heart attack, heart condition, heart trouble, or any abnormality of the heart prior to this date? .... ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): ________________________________

   The person(s) named in question 6b will be excluded from coverage for any hospital or intensive care confinement resulting from any disease or disorder of the heart, and shall be limited to three days coverage in connection with any other hospital intensive care confinement and will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy/rider issuance.

Section D: Other Information

1. Is this insurance to replace any other cancer insurance you currently have? .... ☐ Yes ☐ No

   If "Yes," provide name of insurance company: ________________________________

2. Have you received the Outline of Coverage? .... ☐ Yes ☐ No

QUESTIONS 3 AND 4 APPLY IF ANY PERSON TO BE INSURED IS AGE 65 OR OLDER:

3. Have you received a copy of the "Guide to Health Insurance for People with Medicare"? .... ☐ Yes ☐ No
4. Have you received a copy of the "Medicare Duplication Acknowledgment Form"? .... ☐ Yes ☐ No
5. Has anyone proposed for coverage used any form of tobacco within the past 36 months? .... ☐ Yes ☐ No

   If "Yes" list name(s):

   ____

Section E: Declarations

I certify that I have read, or had read to me, the completed application and realize that any false statement or misrepresentation thereon which materially affects the insurance company's acceptance of any person for coverage under a policy or rider may result in loss of coverage for that person during the first two policy years (six months if such person is age 65 or over). I also understand the benefits provided are payable for loss resulting from a positive diagnosis of cancer or specified disease (if applied for) that begins more than 30 days after the effective date of coverage for each insured person. I also understand that benefits for cancer screening tests will only become effective 60 days after the effective date of coverage for each insured person. There is no interim coverage provided. The "Policy Effective Date" will be the date recorded on the Policy Schedule by the Home Office. It is not the date the application is signed.

I understand that the policy I am applying for has a pre-existing conditions limitation. A pre-existing condition means the existence of symptoms of a Cancer or Specified Disease (if applied for) which would cause an ordinarily prudent person to seek diagnosis, care or treatment within five years prior to the effective date of coverage for each Insured Person or a condition of a Cancer or Specified Disease (if applied for) for which medical advice or treatment was recommended by a Physician or received from a Physician wihtin five years prior to the effective date of coverage for each Insured Person. I also understand that any premiums deducted prior to the effective date of the policy are pre-paid premiums and will be applied to coverage beginning on the effective date.

Dated at ______________________________ Date ______________________
City State Month Day Year

Signature of Applicant ____

Signature of Agent ______________________________ Agent # ______________

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 4884 • 200 Westlake Park Blvd. • Houston, Texas 77210-4884

EMPLOYEE PAYROLL AUTHORIZATION

I hereby authorize my employer and Philadelphia American Life Insurance Company and its business associates to share and exchange my confidential information as well as the confidential information of any of my family members applying for coverage for the purpose of facilitating payroll deduction of my premiums for coverage. I understand confidential information to be the information on my application for coverage including: name, social security number, date of birth, premium amounts, type of coverage, health information and whether I (or any family member) is or is not issued coverage for medical or any other reason. My employer and Philadelphia American Life Insurance Company may not share any other medical information unless I provide specific additional authorization.

Employer: ____

Date: ______________________________

Print Employee Name: ______________________________________

Employee Signature: _______________________________________

Form 433N 7-05

Submit with Application

1-800-554-0092
Fax: 1-866-521-7902

Request for Automatic Payment Plan (PAC)

Note: This form allows your financial institution to pay the premiums for you automatically. ***Send this form and voided check to the Home Office.***

Authorization to withdraw funds by Philadelphia American Life Insurance Company. As a convenience to me, I authorize you to make payments to Philadelphia American Life Insurance Company by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive notice from me to revoke it.

X ____________ X ______________________________
DATE NAME OF INSURED (Please Print)

Financial Institution ______________________________

Routing No. ______________________________

Account No ______________________________

X ______________________________
AUTHORIZED SIGNATURE AS SHOWN ON ACCOUNT

Policy Number X ______________________

☐ Withdraw on the due date of my policy.
☐ Withdraw on the following date:

____

Withdraw from my:
☐ Checking Account ☐ Savings Account ☐ Other

Withdraw from my account:
☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Form 571 Rev. 9-05

Philadelphia American Life Insurance Company

Home Office: Located at 200 Westlake Park Blvd, P.O. Box 4884, Houston, Texas 77210-4884
A STOCK COMPANY

ELIMINATION RIDER

RIDER EFFECTIVE DATE: (same as Policy Effective Date if no date shown):____________________

In consideration of the issuance or reinstatement of the Policy to which this Rider is attached, it is hereby understood and agreed that the person named in the application as having a condition listed below prior to the date the application was signed, is excluded from coverage as indicated below:

A. ☐	Skin Cancer	We will not be liable for any loss resulting from skin cancer affecting ________________________ for a period of two (2) years from the Rider Effective Date. Coverage for anyone excluded under this section is limited to loss resulting from any cancer other than skin cancer.
B. ☐	All Cancers Including Malignant Melanomas	We will not be liable for any loss resulting from cancer (including skin cancer) affecting __________________, who is completely excluded from cancer coverage and coverage for cancer screening tests under the Policy and any attached riders.
C. ☐	Specified Diseases (If Rider Form 8311N is applied for)	We will not be liable for any loss resulting from________________________ ______________________________ (named Specified Disease) affecting ____, who is excluded from coverage for the named Specified Disease.
D. ☐	Hospital Intensive Care (If Rider Form 8290N is applied for)	We will not be liable for any benefits under the Hospital Intensive Care Confinement Benefit Rider for_____________________________ for loss resulting from any disease or disorder of the heart. Further more, the hospital intensive care benefits for such person will be limited to three days in connection with any one period of confinement for any other injuries or sickness, not the 30 days as stated in the Policy/Rider.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Secretary

President

Accepted by: ____________________________
Signature of Applicant