

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** \$ _____ \$ _____
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 _____ Daytime Phone Number _____

5. Billing Address (if different than above)

Street _____ City _____ State _____ Zip _____ Daytime 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 If YES,
 Chronic Cough Tuberculosis Shortness of Breath Sleep Apnea Other Lung Disorder Check all that apply

15B. Circulatory System YES NO
 Heart Disease Coronary Artery Disease High Blood Pressure Elevated Cholesterol/Triglycerides If YES,
 Varicose Veins Irregular Heartbeat Chest Pain Heart Murmur Check all that apply
 Stroke/TIA Phlebitis Blood Clot Blood Disorder Poor Circulation

15C. Digestive System YES NO
 Ulcers Gastritis Colitis Stomach Gallbladder/Gall Stones If YES,
 Hernia Hemorrhoids Spleen Bleeding Esophagus/Reflux/GERD Check all that apply
 Pancreas Liver/Bile Ducts Hepatitis (A ____, B ____, C ____) Intestinal Disorder

15D. Endocrine System YES NO
 Pancreas Diabetes Abnormal Blood Glucose Pituitary Other Gland Disorder If YES,
 Thyroid Goiter Addison’s Disease Sugar in the Urine Check all that apply

15E. Reproductive System (Male/Female) YES NO
 Ovaries/Ovarian Cyst Caesarean Section Miscarriage Menstrual Disorder If YES,
 Infertility Cervix Abnormal PAP Herpes Check all that apply
 Endometriosis Uterus/Uterine Fibroids Genital Warts Prostate/Elevated PSA Sexually Transmitted Diseases

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 If YES,
 Foot/Knee Disorder TMJ/Jaw Disorder Lupus Herniated/Slipped Disc Check all that apply
 Arm/Shoulder Disorder Joint Disorder/Replacement Bursitis Collagen Vascular Disorder
 Connective Tissue Disorder Muscle/Ligament/Tendon/Cartilage Disorder Spinal Manipulation/Adjustment

15H. Nervous System YES NO
 Epilepsy Convulsions Seizures Paralysis Parkinson’s Disease If YES,
 Head Injury Brain Disorder Dementia Headaches/Migraines Alzheimer’s Disease Neuropathy Check all that apply

15I. Mental/Nervous System YES NO
 Anxiety/Depression Attention Deficit/ADD/ADHD Neurosis/Psychosis Sleep Disorder If YES,
 Bi-Polar Disorder Chemical Imbalance Psychiatric Treatment or Counseling Eating Disorder 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

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company (USL&H) for insurance under the policy issued to the Apex Benefit Care Insurance Trust. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, USL&H's only obligation will be to return any premium paid; and, (c) that USL&H will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from USL&H and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give USL&H, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. (For residents of Arizona, this authorization is valid for 180 days for any HIV-related information.) I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to USL&H, P.O. Box 388342, Chicago, Illinois 60638. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that USL&H has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original. Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form. 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 may be guilty of a crime and may be subject to fines and confinement in prison. **Disclaimer** — If premiums are paid from your employer's account, it is understood that: 1. USL&H assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor, will be fulfilled by the employer, as his own legal counsel may determine. 2. The policy is not guaranteed issue and will be fully underwritten by the Company which may result in the exclusion from coverage of certain family members (if applicable) and health conditions. USL&H assumes no responsibility for collection of premiums and/or the failure of your employer to remit them on a timely basis.

Dated at _____
 _____ City _____ State _____ Zip _____ Date _____

 Applicant's Signature _____ Spouse's Signature (if to be covered) _____

 Dependent's Signature (If 18 or older) _____ Dependent's Signature (If 18 or older) _____

 Guardian/Representative's Signature/Relationship to Applicant _____ Dependent's Signature (If 18 or older) _____

Agent Information: _____
 Printed Name _____ Address _____ Phone # _____

I have truly and accurately recorded the information personally supplied by the applicant. Further, I have made no representations to the applicant other than those contained in the sales brochure.

Agent # _____ Signature _____ E-Mail _____ General Agent _____

Method of Payment: Annual Semi-Annual Quarterly Direct Monthly Direct PAC Credit Card List Bill
 Credit Card Number: _____ Visa MC Discover Exp. Date: _____

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

Bank Name _____ Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life and Health Insurance Company, 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 _____

(PLEASE TURN OVER TO FINISH APPLICATION)

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

6640 SOUTH CICERO AVENUE
BEDFORD PARK, ILLINOIS 60638
800/875-4422