Cash Cancer Plan

No one plans to get cancer.
Be prepared if it happens to you.

HUMANA
Guidance when you need it most

Humana Financial Protection Products

GNA06VOHH 11/09 MI

Cash Cancer Plan

Ensure financial peace of mind for you and your family.

One out of every two men and one out of every three women will get cancer.* That's a fact that should make you think. But instead of worrying, why not prepare? Humana's **Cash Cancer Plan** is a cancer insurance policy that pays cash to you, or your designee, to help with unexpected, out-of-pocket expenses.

If you or a member of your family is diagnosed with a covered cancer, ** **you'll receive a cash payment to use however you want.** For instance, use it to help with:

- ✔ An unexpected loss of income
- ✔ Travel to national cancer centers
- ✔ Trial or experimental treatments
- ✔ Personal home care and household expenses

Cash Cancer Plan Features

Choice of Who's Covered					
Individual – Single Parent – Family					
Benefit Amount					
$10,000	$20,000	$25,000	$30,000	$40,000	$50,000
Two Payment Methods					
Pay premiums for life of the policy or until claim is filed.			Pay premiums for 20 years (without lapse). Coverage continues with no additional premiums required.		

Optional Return of Premium Rider

If there are no claims during the term of the rider, premiums will be refunded if the premiums are paid according to the following schedule:

- If the policy is issued when you're age 18-64, and you make no claims after 20 years of coverage, 100% of your premiums will be refunded.
- If the policy is issued when you're age 65-69, and you make no claims after 10 years of coverage, 50% of your premiums will be refunded.

Cash Cancer Plan is Kanawha Insurance Company policy Form 70130 MI and optional rider policy Form 70140. 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. Humana's Cash Cancer Plan is for protection in the event you are diagnosed with cancer in the future. Please do not apply for this plan if you have ever been diagnosed with cancer. No benefit is payable for a pre-existing condition within the first 12 months of policy issuance. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.

* Source: Cancer Facts & Figures 2009, American Cancer Society.
** Covered cancer means first diagnosis and does not include skin cancer other than malignant melanoma.

HUMANA®
Guidance when you need it most

Application for Cash Cancer Plan

Kanawha Insurance Company

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PLEASE INDICATE: ○ NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Address (Street or R.R.)

City | State | ZIP Code | Home Telephone ( ) -

Have you used Tobacco in any form in the last 12 months? ○ Yes ○ No

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Have you used Tobacco in any form in the last 12 months? ○ Yes ○ No

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

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.

Child Four

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

BENEFIT SECTION

Plan Type ○ Individual (adult or child) ○ Single Parent (parent and all children)
○ Family (2 parents and all children) ○ Children Only (use single parent rate)

Benefit ○ $10,000 ○ $20,000 ○ $25,000 ○ $30,000 ○ $40,000 ○ $50,000

Payment Period ○ Lifetime Payment ○ Payment for 20 years **Return of Premium** ○ Yes ○ No

Payment Method ○ Bank Draft ○ Credit Card ○ Direct Bill/Check (Annual Billing Only)
(Complete Bank Draft or Credit Card Authorization.)

Payment Mode ○ Monthly ○ Semi-annual ○ Annual

Total Modal Premium $.
(Total modal premium must accompany application)

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

I hereby represent to Kanawha Insurance Company to the best of my knowledge, information and belief:

	Proposed Insured	Spouse	Child 1	Child 2	Child 3	Child 4
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
1. Has any Proposed Insured ever been medically diagnosed as having, or been treated by a physician for: internal cancer, melanoma, leukemia, Hodgkin's Disease, malignant growth, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or tested positive for the Human Immunodeficiency Virus (HIV)?.....	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Will this policy replace any existing coverage?.....	○ ○					

If "Yes", list company name, insured, and policy number.

_____

_____

3. I agree the policy will not be effective until it has actually been issued and understand no benefits are payable for a diagnosis of cancer in the first 30 days after the policy effective date.
4. I understand 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.
5. I understand any person who, with intent to defraud or knowing he/she is facilitating a fraud against any insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signed At _____ State
City

_____
Signature of Proposed Insured/Owner

/ /
Date (MM/DD/YYYY)

Payor Information

Payor Information (First, MI, Last Name) (If different than the Proposed Insured) Suffix

Social Security Number

- -

Address (Street or R.R.)

City State ZIP Code

AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Attach Voided Check

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

Route & 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 Policy is issued.
3. This Authorization shall not be construed as modifying any provisions of the Policy.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the Policy 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) ___ / ___ / ____

INSURANCE PRODUCER'S USE

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

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer _____ ___ / ___ / ____

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