APPLICATION

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

HOSPITAL INDEMNITY POLICY (Form H-0204)

Calendar Year Maximum Benefit ○ $100,000 ○ $250,000 ○ $1,000,000

Number of Units Per Policy ○ 1 Unit ○ 2 Units ○ 3 Units

Calendar Year Deductible ○ $100 ○ $500 ○ $1,000 ○ $2,500 ○ $5,000

Tobacco User-Applicant ○ Yes ○ No Tobacco User-Spouse: ○ Yes ○ No

ACCIDENT EXPENSE POLICY (Form H-0089)

Benefit Amount ○ 1 Unit ○ 2 Units

Plan Type ○ Individual ○ Individual & Spouse ○ Single Parent ○ Family ○ Child Only (per Child)

Accident Expense Optional Benefits:

Disability Income Benefit Rider ○ Occ. Type 1 ○ Occ. Type 2

Number of Units ○ 1 Unit ○ 2 Units

Benefit Period ○ 12 Months ○ 24 Months

REQUESTED EFFECTIVE DATE: _____

PAYMENT MODE: ○ Monthly ○ Quarterly ○ Semi-Annual ○ Annual

PAYMENT TYPE: ○ Monthly Bank Draft ○ Direct Bill ○ List Bill

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:

APPLICANT: _____

SPOUSE: _____

HOSPITAL INDEMNITY INSURANCE PREMIUM	$_____
ACCIDENT EXPENSE INSURANCE PREMIUM	$_____
ACCIDENT DISABILITY RIDER PREMIUM	$_____
APPLICATION FEE (non-refundable)	$_____
TOTAL PAYMENT DUE	$_____

HOSPITAL INDEMNITY INSURANCE STATEMENT OF ELIGIBILITY AND OTHER INSURANCE

IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
1. Within the past 10 years, has any Applicant been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B or C, insulin-diabetes including neuropathy, ulcerative colitis or Crohn's, Down's syndrome, mental retardation, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, cystic fibrosis, heart attack, coronary bypass, cerebral palsy, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized **more** than 3 times in the past year?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. In the past 10 years, has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Is the primary Applicant or any of the Applicant's dependent's (spouse, child(ren) under age 25), whether applying for coverage or not, currently pregnant or have a pending adoption?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 5 years has any Applicant been diagnosed with, taken medication or been treated for internal cancer, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 4 years has any Applicant used drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. In the past 6 months, has any Applicant been confined to a nursing facility (except for short term rehabilitation), bedridden, or been told they are disabled?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
7. Does any proposed insured intend to reside outside the US?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

THE FOLLOWING QUESTIONS APPLY TO THOSE FAMILY MEMBERS THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.

8. Has anyone to be insured used any form of tobacco (including cigars, pipe or chewing tobacco) within the past 24 months?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
9. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions and **has seen a physician more than twice for any of these conditions? Please add one (1) point for each condition and underline the condition(s).**								
a. kidney stones, kidney/bladder or urinary infections, hepatitis A,	☐	☐	☐	☐	☐	☐	☐	☐
b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,	☐	☐	☐	☐	☐	☐	☐	☐
c.(TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,	☐	☐	☐	☐	☐	☐	☐	☐
d. obsessive-compulsive disorder, psychosis, schizophrenia,	☐	☐	☐	☐	☐	☐	☐	☐
e. migraines, endometriosis, uterine fibroids or uterine cyst.	☐	☐	☐	☐	☐	☐	☐	☐