



Application to: Conseco Insurance Company

Administrative office: 11825 N. Pennsylvania Street, Carmel, Indiana 46032

SECTION I

Is this a reinstatement? Yes [] No [] Is this an upgrade of existing coverage? Yes [] No []

If yes to any of the above, provide existing account number: _____

Effective date: _____

SECTION II

Form with fields for Applicant's Name, Spouse's Name, Address, Employer's Name, etc.

SECTION III

Please indicate below the type of insurance applied for and answer all of the following health questions. If you answer "yes" to any of the health questions 1 through 5, the person(s) named will be completely excluded from insurance.

- 1. Is anyone to be insured under the policy currently confined to a hospital or nursing home, or has a physician recommended such confinement?
2. Has anyone to be insured under this policy ever been treated for or diagnosed by a physician as having: Alzheimer's Disease, Dementia, etc.
3. In the past 10 years has anyone to be insured been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
4. Within the past 10 years has anyone to be insured under this policy ever been treated for or diagnosed by a physician as having any internal cancer, or skin cancer (except basal cell cancer)?
5. Within the past 24 months has anyone to be insured under this policy been confined in a Hospital, had outpatient surgery, received medical treatment in an emergency room, or missed five consecutive days of work for any of the following: Angina, Stroke, etc.

List name(s) of person(s) answering "Yes" to any question 1 through 5. _____

has answered "Yes" to one or more of the above questions. This person(s) will not be covered under the policy.

- 6. Is anyone to be insured under this policy currently pregnant?
7. Does this insurance replace any insurance anyone to be insured now has with any other company?
8. Does anyone to be insured under this policy have other insurance which pays benefits for each day hospitalized/hospital confinement?

CONSECO INSURANCE COMPANY

**AUTHORIZATION FOR UNDERWRITING PURPOSES
Pursuant to the HIPAA Privacy Rule §164.508(c)**

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer or Government agency to disclose personal information about me as described below.

This authorization was prepared by Conseco Insurance Company for purposes of obtaining personal information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization is any and all health information being requested by Conseco Insurance Company for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Conseco Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Conseco Insurance Company, or, so long as Conseco Insurance Company has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

ATTN: Privacy Office
Conseco Insurance Company
PO Box 1916
Carmel, Indiana 46082-1916

I understand that my application for insurance can be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four months from the date of my signature. A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization

Signature of Individual and Date

(Please Print) Name of Representative with authority to act on behalf of the Individual Whose Information Is Covered By This Authorization

Relationship of Representative to Individual

Signature of Representative and Date

White - APPLICANT COPY Pink – HOME OFFICE COPY



Conseco insurance companies
Request to draft premium by Electronic Funds Transfer (EFT)

Please check the appropriate options.
Be sure to include a VOIDED CHECK or this request cannot be processed!

- 1. Administrative office will process the draft for the initial premium within 48 hours of receiving the application
2. Include a copy of a voided check with initial premium by EFT in the special remarks section of the application.
3. Complete the authorization below.
4. Fax completed form with application and copy of a voided check to (800) 906-3926, Attn: New Business department

Authorization to draft initial premium

Upon the receipt of this form please process a draft for the initial premium, in the amount of \$ _____, for the application shown below. I am aware that the draft will be processed within 48 hours of receipt of this request in the administrative office.

YES! PLEASE DEDUCT FUTURE PREMIUMS

By selecting this option you are authorizing subsequent renewal premiums to be deducted from the bank account listed above. These premiums will be deducted on a monthly basis on the _____ day of the month.

AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY CONSECO HEALTH INSURANCE COMPANY, CONSECO LIFE INSURANCE COMPANY, OR CONSECO INSURANCE COMPANY

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Conseco Health Insurance Company, Conseco Life Insurance Company, or Conseco Insurance Company. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either 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 shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to the Company, at its administrative offices in Carmel, Indiana. This plan may be discontinued by the Company upon thirty (30) days written notice to the Owner indicated in the agreement. The Company is instructed to forward authorization to you.

Applicant Name _____

Date of Birth or SSN _____

Accountholder Name (if different) _____

Financial Institution/Bank Name _____

ABA Routing no. _____ ACH Routing no. _____

Bank Account no. _____ Checking [] Savings []

Account holder signature _____ Date _____

The acceptance of this form and the initial premium payment is not a guarantee that the application for insurance will be approved and a policy issued.

Conseco Health Insurance Company, Conseco Life Insurance Company, and Conseco Insurance Company, a life and health insurance company, are members of the Conseco insurance companies.