Cancer Insurance Application To: Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902

NAME OF APPLICANT: ____________________
Last | First | MI | Soc. Security No. | Date of Birth | Age

ADDRESS: ____________________
Street | City | State | Zip | Phone

NAME OF EMPLOYER: ____________________ Employment Date | Beneficiary | Relationship

NAME OF SPOUSE: ____________________
Last | First | MI | Soc. Security No. | Date of Birth | Age

☐ Cancer Ultimate III ☐ Cancer Economizer III
Daily Hospital Room ☐ $300.00 ☐ $250.00 ☐ $200.00 ☐ $100.00
Radiation & Chemotherapy ☐ $25,000 ☐ $20,000 ☐ $15,000 ☐ $10,000
Intensive Care ☐ $600 ☐ $450 ☐ $300
Dread Disease ☐ First Occurrence ☐ 1 Unit ☐ ½ Unit
Cancer Disability ☐ $500 ☐ $250
Cancer Death ☐ $10,000 ☐ $5,000
☐ Return of Premium
☐ Other: ________

☐ Male ☐ Female
☐ Two Parent Family
☐ One Parent Family
☐ Individual

PREMIUM
Cancer ________
IC ________
DDB ________
FOB ________
DIS ________
CDB ________
ROP ________
Other ________
Total ________

PREMIUM MODE:	☐ ANNUAL	☐ SEMI-ANNUAL	☐ QUARTERLY	☐ MONTHLY
PREMIUM METHOD:	☐ BANK DRAFT	☐ DIRECT BILLING	☐ PAYROLL DEDUCTION	Monthly Direct Bill Not Available

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

REPRESENTATION AND AGREEMENT:
I hereby represent that to the best of my knowledge, information and belief all persons proposed for coverage:

CANCER INSURANCE:

1. No person to be insured under this Policy has within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, or radiological exam (e.g. X-Ray, MRI, CAT Scan), except ____________________ who is to be excluded from the coverage of this Policy.
   (If none, write none)
2. No person to be insured under this Policy has within the last 7 years, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form except ____________________ who is to be excluded from the coverage of the Policy.
   (If none, write none)
3. No person to be insured under this Policy has now or has ever been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), in any form, and no person to be insured under this Policy has tested positive for the human immunodeficiency virus (HIV) except ____________________ who is to be excluded from the coverage of the Policy.
   (If none, write none)

DREAD DISEASE: Do not currently have or never had treatment or diagnosis of: Adrenal Hypofunction (Addison's Disease) • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Cystic Fibrosis • Diphtheria • Encephalitis • Legionnaire's Disease (excluding Pontiac Syndrome) • Meningitis (Epidemic Cerebrospinal) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Lyme Disease • Niemann-Pick Disease • Osteomyelitis • Neurolysis • Poliomyelitis • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scarlet Fever • Sickle Cell Anemia • Smallpox • Tay-Sachs Disease • Tetanus • Toxic Epidermal • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Whipple's Disease (Intestinal Lipodystrophy) except, ____________________ who is to be excluded from coverage of this benefit.
(If none, write none)

INTENSIVE CARE RIDER: Has any proposed insured ever been diagnosed or treated for Heart Disease, Heart Attack, Any Heart Condition or Heart Trouble or Any abnormality of the Heart, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If yes, state name ____________________ Any person named will not be covered by this rider

(b) If this is a Two Parent Family Rider, is any person to be insured currently pregnant or taking fertility drugs? ☐ Yes ☐ No

If yes, state name ____________________

(c) If this is a One Parent Family Rider, are you, your wife, fiancee or companion currently pregnant or taking fertility drugs? ☐ Yes ☐ No

If yes, state name ____________________
If yes to question (b) or (c), we will issue an individual rider on the adult male family member only.

CANCER DISABILITY: Is the Primary Insured presently employed and working a minimum of 20 hours per week? ☐ Yes ☐ No

Do you have any other health insurance in force at this time? ☐ Yes ☐ No
If Yes, amount, name and address of Company ____________________
Will the Policy applied for replace any health insurance in force on any proposed insured? ☐ Yes ☐ No
I hereby acknowledge receipt of an outline of coverage.
I understand that policy and rider issuance is based on all statements and answers indicated above, which are complete and true to the best of my knowledge and belief. I further understand that the policy and rider is not effective until the effective date specified in the policy and that the cancer policy applied for will not pay benefits for cancer which is diagnosed before 30 days following the effective date of the cancer policy.

Signed at ________ City ________ State this ________ day of ________ year ________

________ Signature of Proposed Insured

________ Signature of Licensed Agent ________ Agent No.

________ Signature of Licensed Agent ________ Agent No.

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