

CONSECO INSURANCE COMPANY
A life and health insurance company



Accident Secure[®]

PLUS

Accidental injury and disability income
supplemental health insurance

Application book • Texas

For Disability Coverage (Only available for Primary Applicant). If the answer to any question 4 through 6 is "Yes", you are not eligible for the disability coverage.

4. Are there any material or substantial job duties you are currently unable to perform due to sickness, maternity or injury? Yes No
5. In the past 12 months have you been off work for 10 or more consecutive workdays due to illness or injury (other than for normal pregnancy)? Yes No
6. In the past 6 months, have you taken prescribed medication for the treatment of an injury, disease or disorder of the back, neck or joints? Yes No

For Sickness Disability Rider (Only available for Primary Applicant). If the answer to any question 7 through 10 is "Yes", you are not eligible for the Sickness Disability Rider.

7. Have you ever been treated for or diagnosed by a physician as having any of the following conditions? Yes No
- | | |
|----------------------------|---------------------------------------|
| Alzheimer's Disease | Cardiomyopathy |
| Chronic Fatigue Syndrome | Chronic Hepatitis |
| Chronic Liver Disease | Chronic Obstructive Pulmonary Disease |
| Crohns Disease | Emphysema |
| Fibromyalgia | Heart Valve Replacement |
| Insulin Dependent Diabetes | Diabetes Diagnosed Prior to age 40 |
| Multiple Sclerosis | Muscular Dystrophy |
| Pulmonary Fibrosis | Regional Enteritis/Ileitis |
| Rheumatoid Arthritis | Psoriatic Arthritis |
| Rheumatic Fever | Stroke or TIA |
| Systemic Lupus | Cerebrovascular Accident |
| Ulcerative Colitis | Schizophrenia |
| Vascular Insufficiency | Parkinson's Disease |
8. In the past 10 years, have you been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
9. In the past 5 years, have you been treated for or diagnosed by a physician or had surgery for any of the following conditions: Yes No
- | | |
|-------------------------|--------------------------|
| Angina | Atrial Fibrillation |
| Carpel Tunnel Syndrome | Congestive Heart Failure |
| Coronary Artery Disease | Coronary Angioplasty |
| Heart Disorder | Coronary Bypass Surgery |
| Drug or Alcohol Abuse | Heart Attack |
| Kidney Disease | Sciatica |
| Cancer | |
10. In the past 12 months, have you been confined to a hospital or received medical treatment in an emergency room for any of the following: Yes No
- | | |
|----------------------------|-------------------|
| Sickle Cell Anemia | Hypertension |
| Chronic Bronchitis | Asthma |
| Epilepsy/Seizure | Pancreatitis |
| Gastric Bypass | Blood Disorder |
| Diverticulitis | Joint Replacement |
| Mental or Nervous Disorder | Aneurysm |

SECTION IV Dependent Child Coverage (Please Print and fill out completely) (Each Child to be insured must meet policy eligibility requirements)		
Name	Child(ren) Relationship to Primary Applicant	Date of Birth

Check here if additional space is needed and attach separate sheet.

Other Accident and Sickness Insurance (Please Print and fill out completely.)		
Name of Company	Type of Insurance	Monthly Benefit Amount(s)

Check here if additional space is needed and attach separate sheet.

SECTION V

Coverage Selection:

Accidental Death and Dismemberment (base coverage only) Level 1 Level 2

Disability Coverage (Available to Primary Applicant only)

Off the Job Disability* 24 hour Accident Short Term Disability* None

Optional Riders:

Sickness Disability* Public Safety*

Choose One Disability Benefit Amount this amount will be for any disability coverage or disability rider selected (based on income):

Disability Coverage: \$500 \$1,000 \$1,500 \$2,000

Sickness Disability Rider: \$500 \$1,000 \$1,500 \$2,000

*only available for Primary applicant

Select Type of Coverage:

Individual Individual plus child(ren) Individual plus spouse Family

Payment Mode:	Premium Total:
<p>Current Direct Bill Options:</p> <p><input type="checkbox"/> Monthly Bank Draft</p> <p><input type="checkbox"/> Semi-Annual</p> <p><input type="checkbox"/> Annual</p> <p>Current Payroll Bill Options:</p> <p><input type="checkbox"/> Payroll deduction</p> <p><input type="checkbox"/> Federal Allotment</p> <p>Frequency:</p> <p><input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52</p> <p><input type="checkbox"/> Section 125</p> <p>Monthly Bank Draft is the only mode available on the following:</p> <p><input type="checkbox"/> Credit Union Account Number _____</p> <p><input type="checkbox"/> Employee Non-payroll Account Number _____</p>	<p>Base Coverage \$ _____</p> <p>Sickness Disability Rider \$ _____</p> <p>Public Safety Rider \$ _____</p> <p>Optional Rider \$ _____</p> <p>Total \$ _____</p> <p>Amount Collected \$ _____</p> <p><input type="checkbox"/> Draft initial premium payment (an "Authorization to Draft Initial Premium" form must be completed.)</p> <p><input type="checkbox"/> Check remitted with application</p> <p>*All checks should be payable to: Conseco Insurance Company</p>
Special Instructions:	

Special Instructions:

SECTION VI

Applicant's Statement: I have read or have had read to me, the completed application; all representations are true and complete. I understand that: any false statements or misrepresentations in this application may result in loss of insurance if such false statement materially affected either the acceptance of the risk or the hazard assumed by the Company. The agent has no authority to approve the application, change the policy or waive any policy provisions. For ages 65 and above, I have received the booklet containing insurance advice for people eligible for Medicare. Additionally, I acknowledge that I have received an Outline of Coverage. **No coverage will be effective until all eligibility requirements are met and until the later of: (1) the Effective Date as shown on the Policy Schedule, if issued; or (2) the date the first premium is accepted by Conseco Insurance Company.**

Authorization: I hereby authorize the Medical Information Bureau, or other organization, institution or person, that has any medical or non-medical record or knowledge of me, or any members of my family for whom application has been made, to give the Company any information it may have about me. A photographic copy of this authorization shall be as valid as the original.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined in a state or federal court of law.

Date: _____ Signature of Applicant: _____

Where Signed: _____
(City, State)

This Section to be Completed by Agent: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the applicant.

Date: _____ Signature of Agent: _____

Agency: _____ Agent Number: _____

Agent's E-mail address: _____

Agent's Phone Number: _____

Mail to Policyholder

Mail to Agent

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 Consecoco 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 Consecoco 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 Consecoco 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 Consecoco Insurance Company, or, so long as Consecoco 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
Consecoco 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

APPLICANT COPY

CONSECO INSURANCE COMPANY

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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.

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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

HOME OFFICE COPY

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to Your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Conseco Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, 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 policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present policy.
3. If, after due consideration, you still wish to terminate your present policy and replace it with the new policy, 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 any future claims and to refund your premium as though your policy had 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

Date

Spouse's Signature (if applying)

APPLICANT COPY

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to Your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Conseco Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, 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 policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present policy.
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The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

Date

Spouse's Signature (if applying)

ADMINISTRATIVE OFFICE COPY

DISCLOSURE STATEMENT ALWAYS LEAVE WITH APPLICANT(S)

MEDICAL INFORMATION BUREAU NOTICE - Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. If you apply to another bureau member for life or health insurance, or if a claim is made to such a company, the bureau, upon request, will furnish that company with information about you from its files. We or our reinsurers may release information in our files to other life insurance companies to whom you might apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon your request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's files, you may seek correction from the Bureau as provided by the Fair Credit Reporting Act. The address of the Bureau's information office is: 160 University Avenue, Westwood, Massachusetts 02090. The telephone number is (617) 426-3660.

NOTICE OF INSURANCE INFORMATION PRACTICES - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information, although the information we obtain about you is confidential. In some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

FAIR CREDIT REPORTING ACT NOTICE - As part of our evaluation of your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report among other things may include information as to your character, general reputation, personal characteristics, health and mode of living. Upon your written request and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB-ACC(1/01)

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services.

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Signature of Applicant

For use with Accidental Injury policies.



CONSECO.

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.



CONSECO.

Conseco insurance companies*

CONDITIONAL RECEIPT

Received of _____ this _____ day of _____

the sum of \$_____ being the payment of the initial premium. The health insurance applied for will not take effect until the effective date of the applicant's policy if issued, and the payment of the first premium, whichever is later, provided the applicant remains in good health.

The acceptance of this initial premium payment is not a guarantee that the application for insurance will be approved and a policy issued. In the event your application is not approved, you will be refunded the initial premium amount.

**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.*

COND-RECEIPT

(06/07) 128552
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Policy form: CIC-1022

Conseco Insurance Company
Administrative Office
11825 N. Pennsylvania Street
Carmel, IN 46032

AP-1022-TX (09/08) 131515
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conseco.com



CONSECO
Step up.