

PROFESSIONAL  
INSURANCE  
COMPANY



# Hospital Indemnity Plans

*The Finest in Supplemental Health Benefits*

Health Savings Account (HSA) Supplement

Traditional/Co-pay Supplement

Catastrophic (Cat) Value

Max Plan

Underwritten by Professional Insurance Company  
(In California, PIC Life Insurance Company)

Sun   
Life Financial®

## Choose the Professional Insurance Company (PIC) for the finest in Supplemental Health Benefits!

The gaps are getting bigger. Health plans have higher deductibles and larger out-of-pocket limits annually, while hospital and medical expenses increase tremendously each year. You can protect yourself from the potentially devastating expense of a hospital confinement or surgical procedure with any of the following four plan designs that make up PIC's Hospital Indemnity Plan:

- **Health Savings Account (HSA).** You can keep your existing HSA and purchase this added protection against hospital confinement costs.
- **Traditional/Co-Pay Supplement.** If you have a traditional health plan, this plan design protects you against hospital confinement costs.
- **Catastrophic (Cat) Value.** You can
  1. insure several family members on a limited budget, or
  2. protect yourself from high deductibles.
- **Max Plan.** Get maximum protection against hospital and surgical expenses, outpatient sickness and wellness.

### Guaranteed Issue

PIC Hospital Indemnity Plans are automatically "Guaranteed Issue" to full-time workers in Florida, meaning you can not be turned down for coverage based on your health status. However, this Guarantee Issue program can be discontinued at the discretion of PIC. Once your policy has been approved for Guaranteed Issue, it cannot be cancelled except for nonpayment of premium.

For information about PIC plans in Florida, please contact TGAR/BMC Agency, Inc. at 1-888-358-8808.

To qualify for Guarantee Issue, you must:

- Be actively employed 30+ hours per week at a job that you have held for over 30 days, receiving a W2.
- Be "self-employed" or a 1099 contract employee, you must have a business address that is not your home address.

Policies are Guaranteed Renewable until age 65, and through age 69 if you are continuously employed 30+ hours per week.

### PIC Hospital Indemnity Insurance (HPHI2000)

When used with your group or individual major medical plan, every PIC supplement health plan will allow you to leave the hospital after a period of average confinement with significantly reduced or no out-of-pocket expenses.

- Plans are Guaranteed Renewable to age 65, and conditionally renewable through age 69
- Plans covers any licensed doctor. You can use any doctor or hospital of your choice
- Pays over and above any other insurance benefits that you may have (other than Workers Comp)
- Benefits are paid first dollar with no deductibles and no coinsurance
- Plans cover maternity as any illness
- Issued Primary Insured age 18-69

## PIC Hospital Indemnity Insurance (HPHI2000)

### HSA Supplement

- \$30 Per Day Daily Room Benefit
- Up to \$5,000 First Hospital Confinement
- \$500 Lump Sum upon Admission
- Specific Injury Rider
- \$100 Per Accident

### Traditional/Co-pay Supplement

- \$30 Per Day Daily Room Benefit
- Up to \$5,000 First Hospital Confinement
- Up to \$2,500 per Surgery
- \$100 Per Day Private Duty Nursing
- Specific Injury Rider
- \$100 Per Accident

### Cat Value

- \$500 Lump Sum upon Admission
- \$100 Per Day Daily Room Benefit
- \$500 Per Day in ICU
- Up to \$5,000 First Hospital Confinement
- Up to 5,000 per Surgery
- Anesthesia at 25% amount paid for Surgery
- Specific Injury Rider
- \$100 Per Accident

### Max Plan

- \$500 Lump Sum upon Admission
- \$300 Per Day Daily Room Benefit
- Up to 5,000 per Surgery
- \$100 Per Day Private Duty Nursing
- \$100 Per Accident
- \$1,000 Per Day in ICU
- Up to \$5,000 First Hospital Confinement
- Anesthesia at 25% amount paid for Surgery
- Specific Injury Rider
- \$50 Per Outpatient Sickness visit per insured category (for employee, for spouse and for all children, not each child)

	Monthly Plan Rates			
	HSA Supplement	Traditional/Co-pay Supplement	Cat Value	Max Plan
<b>Employee</b>	\$ 29.91	\$ 35.41	\$ 70.54	\$ 113.64
<b>Employee + Spouse</b>	58.07	69.07	139.33	225.33
<b>Employee + Child(ren)</b>	45.57	54.37	107.08	180.78
<b>Full Family</b>	73.73	88.03	175.37	292.67

### Outpatient Sickness Benefits

You can purchase this Outpatient Sickness benefit in addition to any of the four plan designs listed above; it pays \$50 for up to four different covered sicknesses in a calendar year per insured category (4 for employee, 4 for spouse and 4 for all children, not each child)

	Monthly Plan Rates
<b>Employee</b>	\$ 7.30
<b>Employee + Spouse</b>	14.60
<b>Employee + Child(ren)</b>	19.30
<b>Full Family</b>	26.60

**NOTICE to BUYER:** This policy provides limited benefits and is not a replacement/substitute for comprehensive medical coverage. Benefits provided are supplemental, and are not intended to cover all medical expenses. The coverage(s) described herein contain certain exclusions and limitations as well as terms under which such coverage can be continued or discontinued. For costs and complete details of the plans and services advertised, including availability, please contact your insurance representative.

**For information about PIC plans in FLORIDA, please contact Martin Unger at 800-272-0512**

**Your representative is:**

Agent Name	Phone
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**LIMITATIONS & EXCLUSIONS**

This Policy (including any Rider(s) attached) does not cover losses sustained while, (not applicable in IN), caused by, contributed to (not applicable in IL), or resulting from (in PA does not pay Benefits for loss from):

- a. being legally intoxicated as defined by state law where the loss occurred (not applicable in MN, OK; in SC where the Insured resides; in MN bodily injuries received while the insured was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state intoxication limit) or being (in WI, intentionally) under the influence of any narcotic unless administered on the advice of a Physician (not applicable in CT) (Item a. not applicable in DC, ID, MD, MI, SD, WA); or
- b. alcoholism (not applicable in MN; in PA treatment of) or drug addiction (Item b. not applicable in DC, MD, SD); or
- c. attempted suicide while sane or insane (insane does not apply in MO) or intentionally self-inflicted Injury (in CO suicide or attempted suicide while sane or intentionally self-inflicted injury while sane); or
- d. Mental or Nervous Disorders without demonstrable organic disease (not applicable in DC); or
- e. being exposed to (not applicable in MN) war or any act of war, declared or undeclared or while serving (in FL on active duty) in the armed forces; or (in OK war or act of war, declared or undeclared while serving in the armed forces or any auxiliary unit attached thereto;)
- f. engaging in an illegal activity (not applicable in CT and MD; in CA engaging in a felony; in CT and ID participation in a felony, riot or insurrection; in OK participation in a felony, riot or insurrection; in SC engaging in an illegal occupation or committing or attempting to commit a felony) or
- g. conditions specifically excluded by amendment or Endorsement; or
- h. any Pre-Existing Conditions as defined in this Policy.

This Policy (including any Rider(s) attached) does not pay Benefits for:

- a. care that is primarily for 1) rest; or 2) convalescence; or 3) rehabilitation (not applicable in ID); or
- b. treatment which is rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or Injury sustained while traveling for business or pleasure; or
- c. Dental Treatment or plastic surgery for cosmetic purposes. This exclusion does not apply if the treatment or surgery (in ID, IL reconstructive surgery) is: (1) due to an Injury (in ID, IL incidental to or follows surgery due to an injury, infection or other diseases of the involved part); or (2) to restore normal bodily functions. (In MD benefits will be paid for complications that oc-

cur during the surgery that have not been excluded in any part of this policy; or (d. Payment of health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral); (In ID add: or (3) for congenital disease or anomaly of a newborn Eligible Dependent Child.

**PRE-EXISTING CONDITIONS**

This Policy and any attached Rider(s) do not cover pre-existing conditions whether disclosed in the application or not (In WI and MD, whether disclosed in the application or not does not apply), for the first 12 months (In NM, 6 months; in TX, 6 months for persons age 65 or older on the date coverage begins) beginning on the date that person becomes an Insured on this Policy or Rider. By pre-existing conditions, We mean:

- a. the existence of symptoms (In MN the existence of symptoms during the 2 years preceding the Policy Effective Date of Your coverage for which medical advice or treatment was recommended by or received from a physician) (In SC, a condition misrepresented or not revealed in the application for which symptoms exist) before the Policy Effective Date which would cause an ordinarily prudent (In DC, ordinarily prudent does not apply) person to seek medical advice, diagnosis, care, or treatment during the 2 years (In ID and NM, 6 months; in IL, SD and VA, 12 months) preceding the Policy Effective Date of Your coverage (In CA, MT, NC, PA and WY, not applicable); or
- b. a condition for which medical advice or treatment was recommended by or received from a Physician during the 2 years (In ID, NM and WY, 6 months; in CA, MT, SD and VA, 12 months) preceding the Policy Effective Date of Your coverage. (In NC, not applicable) (In NC, By pre-existing conditions, We mean: those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12 months period immediately preceding the Policy Effective Date. Pre-existing conditions exclusions may not be implemented by any successor plan as to any Insureds who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period that was met under the previous plan.) Any person who was age 65 and over when they become an Insured under this Policy, pre-existing conditions shall mean only those conditions specifically excluded in any part of this contract or attached endorsement. Conditions specifically named or described as excluded in any part of this Policy are never covered. (In WY, credit shall be given to any Insured who was covered by a private or public health benefit plan if the previous coverage was continuous to the date not more than 90 days prior to the Effective Date of this Policy). (In WI and MD, any condition noted in the application and not specifically excluded in any part of the policy is not considered a pre-existing condition.)

Underwritten by Professional Insurance Company (In California, PIC Life Insurance Company) (Wellesley Hills, MA)  
 Professional Insurance Company (In California, PIC Life Insurance Company) is a member of the Sun Life Financial group of companies.  
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SLPC 20037 02/09 (exp. 02/11)

## **The Plan Highlights and How to Fill Out the Enrollment Form**

This is a supplement plan. It pays out the amounts displayed in the brochure. The HSA Supplement has the following features:

1. The first day you are hospitalized it will pay you a total of \$1,030.
2. The second day it pays \$530.
3. On each of the third, fourth, fifth and sixth days, it will pay out \$1,030 per day.

This plan is \$29.91 a month (for an individual).

You can almost double the above payout for an additional \$12.50 a month by adding the FHC rider.

That means:

1. The first day you are hospitalized it will pay you a total of \$1,530.
2. The second day it pays \$1,030.
3. On each of the third, fourth, fifth and sixth days, it will pay out \$2,030 per day.

If you were in the hospital for six days, the plan would pay out \$10,060.

There is a page in this document that describes the qualifications for the FHC rider. Not everyone will be eligible, but most of you will. Please excuse me for being blunt, but the rider is a “no-brainer” if you qualify.

Keep in mind that this is first dollar payment. If you are in the hospital for two days and get a bill for \$3,000, this plan will pay you \$2,500. I can speak from personal experience that this is a big help.

Regardless of any healthcare legislation, you will always have deductibles and out of pocket expenses. The governments' guaranteed issue pool will offer plans with nearly a \$6,000 out of pocket liability for an individual and much more for a family. These supplements are the type of plans you hold forever. Their rates generally do not go up once you purchase them.

### **Filling out the form is not really difficult.**

The top portion is self-explanatory. They are asking for name, address, SSN, height, weight, etc.

There is a check box at the top that asks if you are replacing coverage. Do not check it. This is a supplement and is not used to replace other coverage.

Do not fill in stuff that makes no sense such as group number or payroll number.

They **do want** an employer name, occupation and date of employment. If you are self employed use your business name or your name if you do not operate under a business name. Whatever you use for your business bank account or tax id number is fine.

The next section says Insurance Plans.

Go to the section that says Hospital and where it says Primary Insured, under Base Policy, you are going to put in the cost of the plan. It is in the brochure or you can ask me. That's it. Do not fill in anything else in this section. Currently, it is \$29.91 for an individual, \$58.07 for an individual and spouse, \$45.57 for an individual and children and \$73.73 for a family (it does not matter how many children you have).

The top of the next page says "1. Has Any Proposed Insured" You will answer A, B and C.

If you answer "Yes" for question 1A you will not get this policy. If you answer "Yes" for 1B, they want the details in the box on the page for that purpose. Be sure to fill in all the information they ask for. They are not interested in the fact you might have had a sore throat or an ear infection.

At the bottom of the page they want your signature, city and state where you signed it (must be in Florida) and the date.

The next page is for payment information. Leave the Policy Number blank. They want to know

- Premium Amount (If you take the extra First Hospitalization Rider be sure to add this amount)
- Draft Date (when you want the money to be taken from your account)
- Name of Insured

Fill in the information below the chart and be sure to sign and date this form. They will want a voided check. Nothing will be processed without it.

The Consumer Understanding page needs your name and signature at the top and your initials next to the 5 items. **Make sure you initial the boxes.**

Next is the Premium Calculation Worksheet. Just circle the appropriate items.

Finally, there is a sheet that explains the First Hospitalization Rider. This is a second rider. All of the plans include this feature. The insurance company is letting you purchase a second one for a very nominal amount. This effectively doubles your hospital coverage. Well worth it.

You can scan everything and email it, put in the mail or just fax it to me. Be sure it is filled in neatly and with black ink. We need to be able to refax it.

FAX#: 1-775-254-2881

EMAIL: [getaquote@gmail.com](mailto:getaquote@gmail.com)

Mail: Martin Unger, 5070 NW 96<sup>th</sup> Way, Coral Springs, FL 33076

Call me with any questions.

Martin Unger  
800-272-0512

**FRAUD:** Any person who, knowingly and with intent to injure, defraud, or deceive any insured files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Check if replacing or changing existing coverage in this company. Policy Number \_\_\_\_\_

PERSONS PROPOSED FOR INSURANCE									
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.	
			Primary Insured	/ /				- -	
			Spouse	/ /					
			Child	/ /				COMPLETE SHADED	
			Child	/ /				AREAS IF AVAILABLE	
			Child	/ /					
Address			City		State	Zip		Home Telephone ( )	
Secondary Addressee			City		State	Zip		Home Telephone ( )	
Employer			Date Employed			Hours Worked/Wk			
Occupation		Monthly Income \$		Group Number			Employee/Payroll Number		
Payor or Owner if other than Primary Insured			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security No. - -			Relationship To Primary Insured		
Beneficiary						Age	Relationship		

**FOR THE PAST 30 DAYS:** Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? \_\_\_Yes \_\_\_No. If "No", explain: \_\_\_\_\_

**USED TOBACCO** in the past 12 months? Primary Insured \_\_\_Yes \_\_\_No Spouse \_\_\_Yes \_\_\_No

**WILL THIS POLICY REPLACE OR CHANGE ANY:** Existing Life or Health Insurance in this or any other company? \_\_\_Yes \_\_\_No. If "Yes", complete replacement form where required.

INSURANCE PLANS										Monthly Premium
<b>DISABILITY Primary Insured Only</b>		Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here				
<input type="checkbox"/> HPDI2002	Occ. Class	Injury \$								
<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2	Sickness \$			<input type="checkbox"/>					
<b>RIDERS</b>	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.			
	Primary Ins.	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$		
	Spouse	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$		
	Children	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$		\$
<b>HOSPITAL</b>		Base Policy	<b>RIDERS</b> AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.		
<input type="checkbox"/> 0/0	180 Primary Ins.	\$	\$	\$	\$	\$	\$	\$		
<input type="checkbox"/> 0/0	365 Spouse	\$	\$	\$	\$	\$	\$	\$		
<input type="checkbox"/> 0/3	365 Children	\$	\$	\$	\$	\$	\$	\$		
<b>RIDERS</b>	Private Nurse	Surgical+	Spec. Inj.	1st Hosp. Conf.						
	Primary Ins.	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$			
	Spouse	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$			
	Children	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	\$			\$
<b>CANCER</b>		<b>RIDERS</b> Surgical	Physician Att.	ICU	<input type="checkbox"/> Comp. Care	Disability Income \$500 (Primary Ins. Only)				
Base Policy	\$	\$	\$	\$	First Occurrence					
<input type="checkbox"/> Primary Ins.	<b>RIDERS</b> Can. ICU	Chemo	Hospice	<input type="checkbox"/> \$500	<input type="checkbox"/> 6 Month Benefit					
<input type="checkbox"/> Family	\$	\$	\$	<input type="checkbox"/> \$1000	<input type="checkbox"/> 1 Yr Benefit				\$	
<b>LUMP SUM CANCER</b>		<input type="checkbox"/> Individual	<input type="checkbox"/> 1 Parent	<input type="checkbox"/> 2 Parent	<input type="checkbox"/> Increasing Spouse Benefit Rider					
		<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000			\$	
<b>LIFE</b>	<input type="checkbox"/> LPRT2002	Amount \$	<input type="checkbox"/> Accidental Death Rider		<input type="checkbox"/> Waiver of Premium					
	<input type="checkbox"/> _____	Units Family Rider	Units Children's Rider		<input type="checkbox"/> Other _____					
	<input type="checkbox"/> Opt A	<input type="checkbox"/> Opt B								
									\$	

**I.HAS ANY PROPOSED INSURED:**

- A) Ever tested positive for exposure to the HIV infection, or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? \_\_\_Yes \_\_\_No.
  - B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? \_\_\_Yes \_\_\_No.
  - C) In the past 2 years had a driver's license suspended/revoked? \_\_\_Yes(License # \_\_\_\_\_ State \_\_\_\_\_) \_\_\_No.
- 2. IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? \_\_\_Yes \_\_\_No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

**D1. FOR DISABILITY COVERAGE:** List the amount of any other individual disability insurance currently applied for or in force for the primary insured \$ \_\_\_\_\_

**C1. FOR CANCER COVERAGE:** Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? \_\_\_Yes \_\_\_No

**L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:**

- A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? \_\_\_Yes \_\_\_No
- B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? \_\_\_Yes \_\_\_No
- C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor? \_\_\_Yes \_\_\_No

**Details of "Yes" Answers in 1,D1,C1 or L1.** Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

**Insurance Information Practices:** This notice describes the practices we, Professional Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

**Agreement:** I have read, or had read to me the completed application and agree that 1)all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8)no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

Home Office Corrections and/or Additions Only

**FRAUD:** Any person who, knowingly and with intent to injure, defraud, or deceive any insured files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

X \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/20\_\_\_\_  
**Signature of Primary Insured** City, State Date  
 (Parent if person to be insured is less than 15 years old)

X \_\_\_\_\_ X \_\_\_\_\_  
**Signature of Owner** (If other than Primary Insured) **Spouse**

**AGENT'S STATEMENT:** I, the undersigned agent, also certify that to the best of my knowledge, replacement  is  is not involved at this time.

X \_\_\_\_\_/\_\_\_\_/20\_\_\_\_ \_\_\_\_\_% \_\_\_\_\_  
 Signature of Agent Date Agent's No. % Credit State ID No.

Agent's Name (printed)

# Professional Insurance Company

In California, PIC Life Insurance Company

Mailing Address: P.O. Box 80637, Lincoln, NE 68501-0637 1-800-289-1122

## AUTHORIZATION TO HONOR CHECKS DRAWN BY PROFESSIONAL INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Professional Insurance Company, Lincoln Nebraska, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check is dishonored, whether 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.

### A VOIDED CHECK MUST BE INCLUDED TO PROCESS YOUR REQUEST

#### Policies Covered by the Authorization

Policy Number	Premium Amt.	Draft Date	Name of Insured

If a Draft Date is not selected, the Company will use the drafting date occurring on or prior to the policy issue date.

I hereby authorize you to charge the account indicated **below** to pay the amount due on any insurance policy indicated for which I am obligated to pay premium.

Financial Institution \_\_\_\_\_

City, State, & Zip \_\_\_\_\_

Type of Account (circle one) Checking \_\_\_\_\_ Savings \_\_\_\_\_ Account Number \_\_\_\_\_

Printed Name \_\_\_\_\_ Payor \_\_\_\_\_  
Sign Exactly as it appears on records of Financial Institution.

#### Instructions for Usage and Authorization

To: The Bank Named Above.

So that you may comply with your depositor's request, this Company agrees:

- 1 To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, or order, whether or not genuine, purporting to be executed by this company and received by you in the regular course of business for the purpose of payment (under this plan) including any costs or expenses reasonably incurred in connection therewith.
- 2 In the event that any such check, draft, or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently to indemnify you for any loss even though dishonor results in a forfeiture of insurance or other right.
- 3 To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of payment collection.
- 4 Authorized in a resolution adopted by the Board of Directors of:  
PROFESSIONAL INSURANCE COMPANY

# Consumer Understanding Section

Applicant's Name \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Agent's Name

Martin Unger

- 1) The above referenced agent visited with me in reference to making an application for insurance with your company. The soliciting agent explained to me the provisions showing benefits, waiting periods, limitations, and exclusions. I have received an outline of coverage for the policy(s) for which I applied.

Applicant's Initials \_\_\_\_\_

- 2) I understand that PIC Hospital Indemnity policies are NOT Major Medical policies, and the policy(s) I am purchasing have limited outpatient coverage and doctor benefits. I know that this policy(s) will not cover everything, and that I will be responsible for some costs.

Applicant's Initials \_\_\_\_\_

- 3) I understand that I will not have insurance coverage with PIC until my application(s) has been approved and the Company has notified me that I have been accepted for coverage with a particular effective date. I also understand that in order to receive consideration under a "Guaranteed Issue" basis that I must be gainfully employed and working a minimum of 30 hours per week at the time of application.

Applicant's Initials \_\_\_\_\_

- 4) I understand that even though I may be accepted for coverage I may have exclusionary riders for particular pre-existing medical conditions, and that conditions for which I have sought or received treatment or manifest symptoms in the 12 months prior to my application date will not be covered until 12 months after my policy effective date if fully disclosed, and that I should not let any other coverage lapse until I have received and reviewed the PIC individual policy(s) in my name and found them to be suitable for my needs.

Applicant's Initials \_\_\_\_\_

- 5) I affirm and certify that I have answered all questions on the application(s) truthfully and completely, I have fully disclosed all health history on myself or any other family members listed on the application(s), and I understand that this agent has no authority to waive or modify any answer to any health question(s).

Applicant's Initials \_\_\_\_\_

**BMC: 800-357-2342**

Submit completed applications to:

**BMC Agency, Inc., 1529 Sam Rittenberg Boulevard, Suite 200, Charleston, South Carolina 29407**

\* You can purchase the Outpatient Sickness benefit in addition to any of the four plan designs listed on the reverse side of this form; it pays \$50 for up to four different covered sicknesses in a calendar year per insured category ( 4 for employee, 4 for spouse and 4 for all children, not each child ). If purchased in addition to the MAX PLAN design, this additional premium increases the Outpatient Sickness Benefit to \$100 for up to four covered sicknesses per insured category. This premium amount may be deducted from the posted MAX PLAN premium if you would like to eliminate the \$50 Outpatient Sickness benefit normally included in the MAX PLAN design. Please note that adding this benefit to the HSA Supplement plan design may alter your ability to make tax deductible contributions to a qualified Health Savings Account. Please consult with your personal tax advisor for details.

Subject to underwriting, a proposed insured may apply for either an additional First Hospital Confinement Rider and/or a Cancer Plan. If approved and issued, the Cancer Plan will be issued as a separate policy.

# PIC "Guaranteed Issue" Supplemental Health Insurance

**Premium  
Calculation  
Worksheet**

Available to "full time" ( 30+ Hours / wk. ) Workers in **FL**

Please **CIRCLE** the **MONTHLY** premium amount(s) below that corresponds to your requested coverage.  
Only ONE of these HI plans may be purchased, with or without the optional OP Sickness & FHC Rider(s) and Cancer Plan.

I wish to apply for:  Myself  Myself & Spouse  Myself & Children  Family

	<b>Emp</b>	<b>Emp/Sp</b>	<b>Emp/Ch</b>	<b>Family</b>
HSA Supplement	\$29.91	\$58.07	\$45.57	\$73.73
Traditional/Copay	\$35.41	\$69.07	\$54.37	\$88.03
Cat Value	\$70.54	\$139.33	\$107.08	\$175.37
Max Plan	\$113.64	\$225.33	\$180.78	\$292.67
* Optional Cancer				
*Optional OP Sickness +/-				
* Optional FHC Rider				
<b>Total Monthly Premium</b>				

**\*Optional Outpatient Sickness Rider ( This Rider is NOT Subject to additional Underwriting )**

<b>Employee</b>	<b>\$7.30</b>
<b>Employee Spouse</b>	<b>\$14.60</b>
<b>Employee/ Children</b>	<b>\$19.30</b>
<b>Family</b>	<b>\$26.60</b>

Please **ADD** the \$50 Outpatient Sickness Benefit to my total plan premium. This may be added to ANY of the four plan designs.

Please **REMOVE** the \$50 Outpatient Sickness Benefit from my MAX PLAN premium.

**First Hospital Confinement Rider ( Riders are Subject to underwriting)      Cancer Plan ( FL )**

<b>Employee</b>	<b>\$12.50</b>
<b>Employee/ Spouse</b>	<b>\$25.00</b>
<b>Employee/ Children</b>	<b>\$19.50</b>
<b>Family</b>	<b>\$32.00</b>

<b>Employee</b>	<b>\$12.88</b>
<b>Employee/ Spouse</b>	<b>\$21.77</b>
<b>Employee/ Children</b>	<b>\$21.77</b>
<b>Family</b>	<b>\$21.77</b>

## First Hospital Confinement Rider Upgrade

We believe the PIC Hospital Indemnity benefits to be the very best combination of solid benefits at a reasonable premiums in the Health Insurance industry today. Perhaps the very best, dollar for dollar, is the First Hospital Confinement Rider, included in each and every one of the popular plan packages described in our HI brochure. This benefit can provide as much as \$5,000 over a six day confinement by itself.

We have sought Home Office approval and been granted, under slightly tweaked guidelines to our basic Guaranteed Issue program, the opportunity to apply for a **SECOND**, that is an **ADDITIONAL** First Hospital Confinement Rider! Just to make absolutely certain that you understand, this means **TWO** FHC Riders, the one that comes with the "base" package, and an additional, second one on top, subject to underwriting approval! Here is how it works:

1) Select the rate for the Rider, based upon the plan selected and family composition. If the policy is being applied for as a 'family,' then the rider must be applied for as a family as well. Employee/ spouse base applications must apply for both employee and spouse. Rates are "4 tiered" and the rider must match the base plan.

2) Not being able to answer question 1A), the 'HIV/AIDS' question with a **NO** is an automatic decline for the **RIDER ONLY**. It does not affect the application for the base package of benefits **AT ALL!**

3) Once the applicant survives the 'HIV/AIDS' question, the second question, 1B, asks about conditions for which the applicant has consulted a physician, been treated or been hospitalized in the prior three years. If there are **THREE OR MORE** of these conditions, then the additional FHC Rider will not be issued, once again **not affecting the issue of the base plan at all.**

4) If there are less than three answers provided, that is conditions disclosed under question 1B, then the rider will be issued with an **exclusionary rider placed on the expressed/disclosed condition(s) only**. Even then, the policyholder can petition the company to consider removal of any riders in the future.

**EXAMPLE:** Applicant discloses under question 2B that they had a heart attack in 2009 and have been Diabetic since 2002. The FHC RIDER will be issued with permanent exclusions on the applicant for Heart Attack and Diabetes.

The cost of the FHC Rider is shown on the Consumer Understanding Form, and is repeated here:

<i>Employee</i>	<i>Employee/Spouse</i>	<i>Employee/Children</i>	<i>Full Family</i>
<b>\$12.50/mo.</b>	<b>\$25.00/mo.</b>	<b>\$19.50/mo.</b>	<b>\$32.00/mo.</b>

Include the corresponding premium to the base plan selected on line 7, just above the Total Monthly Premium line, and add it in to get the Total Monthly Premium.

I wish to apply for an additional First Hospital Confinement Benefit Rider, which I understand will be underwritten as described above. I am including the cost of this additional rider, \$\_\_\_\_\_, with my application.

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_ Agent Name Martin Unger