



KEMPER SENIOR SOLUTIONS

**Insurance Benefits Provided by
Reserve National Insurance Company**

| | |
|---|---|
| APPLICANT | Full Legal Name of Proposed Insured _____ |
| | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security No. _____ / _____ / _____ Date of Birth _____ / _____ / _____ |
| | Legal Residence Address _____ Street City State Zip |
| | Mailing Address _____ Street City State Zip |
| | Phone No. _____ / _____ / _____ E-mail _____ |
| Name of Owner if other than Proposed Insured _____ | |

| HOME HEALTH CARE INDEMNITY POLICY | | <i>HOME OFFICE USE: Policy Number(s)</i> |
|--|---|--|
| UNDERWRITING | If you are applying for the Home Health Care Indemnity Policy, please answer the following: | |
| | 1. Do you have any health insurance (including home health care, long-term care, or similar coverage) in force at the time of this application?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 2. If the answer to Question 1 is "Yes," do you intend to replace your current health insurance coverage with the policy applied for? (Complete Replacement Notice if "Yes")..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 4. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 5. Do you acknowledge receipt of an outline of coverage for this policy?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal) | | |
| Base Policy | | Initial Premium \$ _____ |
| Base Policy + Extra Benefit Rider | | Initial Premium \$ _____ |

AGREEMENTS & SIGNATURES

IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application will not be considered in force until issued by the Company and the first premium paid during the insured's lifetime. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. For purposes of insurability and underwriting determinations by Reserve National Insurance Company, I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any members of my family named in this application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114. If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call.

AGREEMENTS & SIGNATURES - CONTINUED

If accepted by the Company, the applicant requests coverage to be effective:

☐ Date of Application ☐ Date of Issue ☐ Other _____

Policy to be Delivered to:

☐ Applicant ☐ Agent

If eligible for Medicare, I have received a "Guide to Health Insurance for People With Medicare" and the "Important Notice to Persons on Medicare."

☐ Yes ☐ No

The sum of \$ _____, which is the ☐ **Annual** ☐ **Monthly** initial premium for the policy(ies) applied for, has been ☐ **Paid to** ☐ **Authorized as a draft on my account by** "Kemper Senior Solutions".

Signed at: _____
City State

Date: _____

Signature of Proposed Insured

Date: _____

Signature of Applicant/Owner/Trustee (if Other than Proposed Insured)

Owner/Trustee Address

Street City State Zip

Agent: I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon.

Signature of Producer #1

Producer Number

Date

N/A

N/A

N/A

Signature of Producer #2

Producer Number

Date

N/A

Print Producer #1 Name

Print Producer #2 Name

Agency Name

BANK DRAFT AUTHORIZATION

Sign the authorization below and provide a voided check **or** provide the information below from the account you would like to use for our bank draft. Your premium will be paid by your bank and will be reflected in your bank statement.

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Kemper Senior Solutions, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit 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 or credit. I further agree that if any such check or credit be 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.

Bank Name

Bank Routing/ABA #

Account #

☐ Checking ☐ Savings

Signature EXACTLY as it appears on Bank Records

Date

☐ Annual ☐ Monthly