



PLEASE PRINT WITH BLACK INK

Select Coverage Plan Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> w/ IC Rdr Plan C <input type="checkbox"/> w/ IC & Enh Rdr Total Premium \$ _____	Select Coverage Type <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Individual <input type="checkbox"/> Family		Select Billing Method <input type="checkbox"/> Bank Draft (Complete the bank authorization) <input type="checkbox"/> Direct Bill <input type="checkbox"/> Payroll Deduction (Sign and Date the Payroll Deduction authorization)		HOME OFFICE USE Policy Number
				Effective Date	

Employer: _____	Occupation: _____	H. O. Corrections:				
Full Name of Applicant	Sex	Date of Birth	Age	Height	Weight	Social Security Number
Spouse:						
Child(ren) Full Name	Date of Birth	Child(ren) Full Name				Date of Birth

- Residence Address: Street: _____ Apt. No. _____
 City _____ State _____ Zip Code _____
 Phone: Home (____) _____ Business(____) _____
- Mailing Address, if not same as above: Street/P. O. Box: _____ Apt. No. _____
 City _____ State _____ Zip Code _____
- Is anyone to be insured covered by any other health insurance issued by National Security Insurance Company? YES NO
 If Yes, list names and policy numbers. _____
- Is anyone to be insured eligible for Medicare for any reason? YES NO
- Has anyone to be insured ever been denied coverage with our company? YES NO
 If Yes, list names _____
- Will the policy applied for replace any health insurance in force on any proposed insured? YES NO
 If Yes, complete the following information.

PERSON	COMPANY NAME/ POLICY NUMBER	TERMINATION DATE	TYPE OF COVERAGE

MEDICAL SECTION 1

- Is any proposed insured currently undergoing any diagnostic tests for or ever been diagnosed with, now being treated or been treated by a member of the medical profession for, taken medication for, or been advised to have diagnostic tests for:

a. Cancer, leukemia, Hodgkin's disease, melanoma, basal cell skin cancer or malignant or benign tumors of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Rabies, Tetanus, Diphtheria, Epidemic Cerebrospinal Meningitis, Undulant Fever, Rocky Mountain Spotted Fever, Smallpox, Tularemia, Bubonic Plague or Typhoid Fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Tuberculosis, Osteomyelitis, Sickle Cell Anemia, Addison's Disease, Hansen Disease or Scarlet Fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Is the applicant actively at work now and has he/she worked at least 30 hours each week performing all duties his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? Yes No
- Is any proposed insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever been tested positive for antigens or antibodies to an AIDS virus? Yes No

For Plan A, skip questions 4 & 5

- Is any proposed insured now being treated for, or ever been treated for: a stroke; heart disease; (including artery disease); high blood pressure; diabetes; kidney disease or multiple sclerosis. Yes No
- If the answer to high blood pressure is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? Yes No

Explain fully all "YES" answers to the questions in the MEDICAL SECTION PART I. Use additional sheet if necessary.

Name of Proposed Insured	Condition	Dates of Treatment

CONDITIONAL RECEIPT—CANCER INSURANCE

Date _____ Received of _____ the sum of _____

If on the date of application the proposed insureds are alive, in sound health, and are risks acceptable to the Company under its rules, limits and standards for the plan applied for, then the insurance applied for will take effect on the date of the application, subject to the terms, provisions, and conditions of the policy(s) applied for. Unless the Company has declined to issue the insurance applied for, the insurance will continue in force until the earlier of: (a) the expiration of the period covered by the payments received herein: or (b) the expiration of 60 days. If the application is accepted and a policy issued, this sum will be applied towards payment of the premium from the effective date of the application. If the Company declines to issue any policy or coverage applied for, the amount for such policy or coverage will be returned to the applicant. All time periods relating to any insurance, coverage, benefit or limitation shall be computed from the effective date appearing on the policy(s) without regard to the period of time between the date of the application and the effective date appearing on such policy(s).

This receipt is issued on the condition that any check, draft or other order for payment of money is good and collectable upon first presentation. This receipt is not transferable and will not be valid for any purpose if any erasures or alterations have been made in the printed form.

 Signature of Agent Agent ID _____

All premium checks must be made payable to National Security Insurance Company. Do not make check payable to the agent or leave payee blank.

MEDICAL SECTION II

List all prescription medications currently being taken or that were taken within the last six months. Use additional sheet if necessary.

Name of Proposed Insured	Medication	Dosage	Condition	Dates

AGREEMENT: I certify that I have read or had read to me the completed application. I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that the statements and the answers are given in this application and any amendments to it will form the basis of any insurance issued. I understand that the policy will, subject to its terms, be considered in force as of the effective date as described in the policy. I also understand that, subject to my acceptance, the Company may, in accordance with its underwriting rules and practices, issue a policy that is other than exactly as applied for by this application. If my answers are incorrect or untrue, National security Insurance Company has the right to deny benefits or rescind my policy, subject to the Time Limit On Certain Defenses provision of the policy. No agent can accept risks, modify policies, or waive any rights or requirements of National Security Insurance Company.

Signed at _____ this _____ day of _____ 20 _____

Signature of Applicant X _____

Affidavit for Agent's Use Only: I certify that the applicant has read or had read to him/her the completed application and that I have truly recorded in this application the information supplied by the applicant. I certify that I have witnessed the signing of this application. I represent that only company approved sales materials were used and that copies of all sales materials were left with the Applicant.

Writing Agent's Signature _____ Agent No. _____

Agent's Name: _____ State License No. _____

HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT

I understand the information obtained by use of the Authorization will be used by National Security Insurance Company to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by National Security Insurance Company to any person or organization **EXCEPT** to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health, to disclose to the National Security Insurance Company or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or National Security Insurance Company has acted in reliance upon this Authorization. My revocation must be submitted in writing to: National Security Insurance Company, 661 East Davis Street, Elba, Alabama 36323.

I also understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

Date: _____ Insured: _____

Bank Draft Authorization

Attach a voided check and have payor (depositor) sign and date bank draft authorization (below):

I hereby authorize National Security Insurance Company to draw funds either by check or electronic funds transfer from my account sufficient to pay my insurance.

Signature of Depositor (as it appears on bank records) <input type="checkbox"/> Checking <input type="checkbox"/> Savings		Date:	
Bank Name:		Bank Account Number:	
		Bank Routing Number:	
Bank Address:	City	State	Zip

Combine with existing draft? Check one box:

Yes. Provide information on one policy on existing draft:

Policy No. _____ Insured's Name: _____

No. Provide requested draft date: _____ **(*Note: Drafts cannot be on the 29th, 30th or 31st)**

NOTICE TO APPLICANT

In making this application for insurance to National Security Insurance Company, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated confidential. National Security Insurance Company, or its reinsurer, may; however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. National Security Insurance Company, or its reinsurer, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.