The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1800 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (614) 487-9675 www.uct.org

APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

Requested Effective Date of Policy

SAMPLE

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street:

City:

State: *Zip Code:*

Area Code: *Telephone Number:*

SPOUSE *Last* *First* *MI*

SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH			SEX
		Month	*Day*	*Year*	☐ Male ☐ Female

Underwriting Risk Classification Question

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Has your Spouse used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:____________________ **Council Location (City & State)** ________________

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

	Question	APPLICANT		SPOUSE	
1.	Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting?	☐ Yes	☐ No	☐ Yes	☐ No
2.	Do you require assistance with shopping, housekeeping or cooking?	☐ Yes	☐ No	☐ Yes	☐ No
3.	During the past two (2) years have you:				
	(a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living?	☐ Yes	☐ No	☐ Yes	☐ No
	(b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter?	☐ Yes	☐ No	☐ Yes	☐ No
4.	Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No	☐ Yes	☐ No
5.	Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse?	☐ Yes	☐ No	☐ Yes	☐ No
6.	Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes	☐ No	☐ Yes	☐ No
7.	Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid?	☐ Yes	☐ No	☐ Yes	☐ No
8.	Are you an insulin dependent diabetic?	☐ Yes	☐ No	☐ Yes	☐ No

BENEFIT OPTIONS

☐ **Short Term Care Insurance Policy**	**Maximum Daily Benefit Amount:** $________		**Elimination Period**	☐ **0 Days** ☐ **20 Days**
Maximum Benefit Period	☐ **100 Days**	☐ **200 Days**	☐ **360 Days**	
Optional Riders	☐ **Home Health Care**	☐ **Compound Inflation Protection**		

REPLACEMENT INFORMATION (MUST BE COMPLETED)

	APPLICANT		SPOUSE	
1. Do you or your spouse have another insurance policy in force (including health care service contract or health maintenance organization contract)?	☐ Yes	☐ No	☐ Yes	☐ No
2. Did you have another limited benefit policy in force during the last six (6) months?	☐ Yes	☐ No	☐ Yes	☐ No

If yes, with which company: (Name and address) ______________________________________

SAMPLE

____

Policy Number: ______________________ If that policy lapsed, when did it lapse? ____________

Daily Benefit Amount : $________________ Benefit Period ____________

Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No ☐ Yes ☐ No

If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATION
MUST BE COMPLETED AND SIGNED

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance company or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or having any non-medical information concerning me to give The Order of United Commercial Travelers of America (UCT), or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America (UCT) to receive my health information or prescription drug usage history and my non-medical information. The released information received by The Order of United Commercial Travelers of America (UCT) will remain protected by federal and/or state regulations as long as it is maintained by the health plan.

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

______________________________ ______________________

Signature of Applicant **Date**

______________________________ ______________________

Signature of Spouse (If applying for separate policy) **Date**

REASON FOR DISCLOSURE

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America (UCT). I understand that failure to provide the authorization to The Order of United Commercial Travelers of America (UCT) *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America (UCT) in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America (UCT) took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original.

______________________________ ______________________

Signature of Applicant **Date**

______________________________ ______________________

Signature of Spouse (If applying for separate policy) **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant or Spouse that is still in force.

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2. List any other health insurance policy you have sold to the Applicant or Spouse in the past five (5) years that is no longer in force.

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I certify that:
1. I have accurately recorded the information supplied by the Applicant and Spouse (If applying for separate policy); and
2. I have given an outline of coverage for the policy applied for to the Applicant and Spouse (If applying for separate policy).

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT			
☐ Annual	☐ Semiannual	☐ Quarterly	☐ Monthly EFT

PREMIUM CALCULATION

	Applicant	Spouse
Short Term Care Only Premium	$	$
Home Health Care Rider Premium	$	$
Compound Inflation Protection Rider Premium	$	$
SUBTOTAL	$	$
Less Spousal Discount (If Applicable)	$	$
Less Non-Tobacco Discount (If Applicable)	$	$
TOTAL MODAL PREMIUM	$	$
Modal Fraternal Dues (If Applicable)	$	$
TOTAL MODAL AMOUNT DUE	$	$

TOTAL AMOUNT PAID WITH APPLICATION $ ____________

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK

Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: ______________________

Account Number: ______________________ **Routing Number:** ______________________

To (Name of Bank): ______________________

Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America 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 other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America 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 forfeiture of insurance.

Date	Signature of Bank Customer

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- 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 and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- 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 such loss even though dishonor results in forfeiture of the insurance.
- 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 said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.