

# UNITED TEACHER ASSOCIATES INSURANCE COMPANY

5508 PARKCREST DRIVE • P.O. BOX 26580 • AUSTIN, TEXAS 78755-0580

## APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

COUNTY NUMBER \_\_\_\_\_ COUNTY NAME \_\_\_\_\_

Applicant's Social Security Number:	Date of Birth			Sex	Height	Weight
	Month	Day	Year			
Applicant						
Spouse						
Child #1				<b>X</b>	<b>X</b>	<b>X</b>
Child #2				<b>X</b>	<b>X</b>	<b>X</b>
Child #3				<b>X</b>	<b>X</b>	<b>X</b>

Address			Occupation		
City	State	Zip	Employer Name		
Beneficiary		Relationship		Employer's Address	
<i>The best time to call me is:</i>					
Home telephone number ( )			Work telephone number ( )		

Individual     Single Parent     Family    Premium Payment Mode: \_\_\_\_\_

**First Diagnosis Cancer Benefit Policy**    Benefit Amount \$ \_\_\_\_\_    Modal Premium \$ \_\_\_\_\_

*First Diagnosis Dread Disease Benefit Rider*    Benefit Amount: \$ \_\_\_\_\_    \$ \_\_\_\_\_

*Intensive Care Unit Benefit Rider*    Benefit Amount: \$ \_\_\_\_\_ per day    Rider Premium \$ \_\_\_\_\_

<b>FOR PAYROLL DEDUCTION:</b>		
Group Name:	Group Number:	Enrollment Fee \$ _____
Is this Section #125? <input type="checkbox"/> Yes <input type="checkbox"/> No    Amount of Deduction: _____		<b>TOTAL PREMIUM</b> \$ _____

1. Is the insurance applied for here intended to replace any existing insurance?     Yes     No  
If yes, list name of Company and policy number: \_\_\_\_\_
2. Are you covered by Medicaid?     Yes     No

**MEDICAL INFORMATION. Answer all questions and circle the applicable conditions. If the answer is "No" to any of the following questions, please mark "none" in the "who" section.**

3. Have you, or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer?     Yes     No    If "Yes", who \_\_\_\_\_ . If the answer is "Yes", any individual named will be excluded from coverage under this policy.
4. Have you, or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma     Yes     No    If "Yes", who \_\_\_\_\_ . Please describe the conditions and treatment period \_\_\_\_\_ .
5. Have you, or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test?     Yes     No    If "Yes", who \_\_\_\_\_ . If the answer is "Yes", any individual named will be excluded from coverage under this policy.

**Please answer questions #6 & #7 if you are applying for the Intensive Care Unit Benefit Rider:**

- 6. Have you, or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of: stroke, heart disease, heart attack or diabetes; or had any other disorder or abnormality of the: brain, heart or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including high blood pressure, unless uncontrolled)?  Yes  No If "Yes", who \_\_\_\_\_ . If the answer is "Yes", any individual named will be excluded from coverage under this rider.
- 7. Are you, or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant?  Yes  No If "Yes", who \_\_\_\_\_ . If the answer is "Yes", any individual named will be excluded from coverage under this rider.

**Please answer the following question if you are applying for the First Diagnosis Dread Disease Benefit Rider:**

- 8. Have you, or any person to be insured under the First Diagnosis Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease?  Yes  No If "Yes", who \_\_\_\_\_ and for which condition \_\_\_\_\_. If the answer is "Yes", any individual named will be excluded from this condition under this rider.

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original. ***I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.***

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

Note to Agent: Is replacement of insurance involved?  Yes  No  
 I hereby give permission to use my name for solicitation purposes.  Yes  No

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_ Read and Signed (U) \_\_\_\_\_  
 Agent Writing Number Applicant  
 \_\_\_\_\_ Check Block if Agent Family Business   
 Agent's Printed Name Agent's License Number

***AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED TEACHER ASSOCIATES INSURANCE COMPANY***

To: \_\_\_\_\_  
 \_\_\_\_\_ (Name of your Bank)

Your Bank's Address: \_\_\_\_\_  
 \_\_\_\_\_ (Street Number, City, State, and Zip Code)

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits drawn on my account by and payable to the order of the **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**, Austin, Texas, 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 debit shall be the same as if it were a check drawn on my account 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 such debit. I further agree that if any such debit is not paid by me for any reason, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such non-payment results in the forfeiture of insurance.

\_\_\_\_\_ (U) \_\_\_\_\_  
 Date (Your signature EXACTLY as it appears on Bank Records) (Account Number)

**IMPORTANT: FOR BANK ACCOUNT IDENTIFICATION, PLEASE ENCLOSE A BLANK PERSONAL CHECK AND MARK "VOID" ON FRONT.**