AdvanceCare

Application for Short Term Disability Insurance

Advance Insurance Company of Kansas℠

For office use only

Sys. number | Rep. number | Date

Section 1 – Applying for:

CLEAR DATA

☑ AdvanceCare Short Term Disability – You must be actively and regularly working 30 hours or more* each week to be eligible for this coverage. Applicants must be less than age 65 to apply.

Elimination Period: The consecutive number of days between the onset of total disability and the time you may be eligible to begin receiving benefits.

15th day for Accident or Sickness

Weekly Benefit: (choose one)

☐ $150

☐ $300 (You must be earning* at least $14 per hour; $420 per week; or $21,000 per year to qualify for this benefit level.)

Maximum Benefit Period: The longest possible length of time for which a benefit may be payable. The length of time a benefit is received depends on the type of, and the severity of, the Total Disability. (choose one)

☐ 13 weeks

☐ 26 weeks

* **IMPORTANT:** If you have a claim, Advance Insurance Company of Kansas (AICK) will verify the number of hours you are actively working each week and your earnings.

Section 2 – Applicant Information

First Name _____ MI _____ Gender ☐ Male ☐ Female

Last Name _____ Suffix _____ Social Security Number _____-_____-_____ Date of Birth _____ /_____ /_____

Mailing Address _____ Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

City _____ E-mail Address _____

State _____ ZIP Code _____ +4 _____

Section 3 – Eligibility Questions

1. Are you actively and regularly working (i.e., performing all of the essential duties of your occupation for wage or salary) 30 hours or more** each week? ☐ Yes ☐ No

   If you answered "No" to this question, please stop here — do not complete or submit this application. You must be actively working 30 hours or more* each week to be eligible for Short Term Disability.

2. What is your job title? _____

** **IMPORTANT:** If you have a claim, Advance Insurance Company of Kansas (AICK) will verify the number of hours you are actively working each week and your earnings.

Please continue on the next page.

Section 4 – General Applicant Information

Your height _____ ft. _____ in.

Your weight _____ lbs.

Section 5 – Applicant's Health Information

Instructions: If you respond 'yes' to a question listing multiple conditions, please circle each condition that applies.

1. Are you currently pregnant? ☐ Yes ☐ No

   If yes, what is your due date? _____ /_____ /_____

2. Are you currently hospitalized, bedridden due to disease, confined to a nursing facility, confined to a wheelchair, or receiving hospice or home health care services? ☐ Yes ☐ No

3. Have you ever been diagnosed with, sought treatment for, or been recommended to have, an organ transplant or bone marrow transplant? ☐ Yes ☐ No

4. Have you ever donated an organ or bone marrow for transplant? ☐ Yes ☐ No

5. Have you ever been diagnosed with AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? ☐ Yes ☐ No

6. Have you ever been diagnosed with Cerebral Palsy, Down Syndrome, Mental Retardation, Muscular Dystrophy, or Spina Bifida? ☐ Yes ☐ No

7. Have you been hospitalized (except for pregnancy or non-life threatening conditions)? ☐ Yes ☐ No

   If yes, please provide:

   a) Diagnosis or details about condition:

   _____

   b) Dates of care:

   _____ /_____ /_____ through _____ /_____ /_____
   Date of Admission Date of Release

   c) Where you were hospitalized:

   _____
   Name of Hospital

   _____ _____
   City State

8. Have you used illegal drugs or received, or been advised by a physician to receive, counseling or treatment for excessive use of alcohol or prescription drugs? ☐ Yes ☐ No

9. Have you been diagnosed with diabetes requiring insulin or been diagnosed with complications of diabetes with regard to eye, blood vessel, nerve damage, or kidney? ☐ Yes ☐ No

10. Have you been diagnosed with, treated for, or prescribed medication for any of the conditions that follow:

    a) Angina (chest pain), coronary artery disease, heart attack, stroke, heart bypass, angioplasty, stent placement, peripheral vascular disease, congestive heart failure, cardiomyopathy, or atrial fibrillation? ☐ Yes ☐ No

    b) Cystic fibrosis, emphysema, chronic obstructive pulmonary disease (COPD), tuberculosis, or black lung? ☐ Yes ☐ No

    c) Alzheimer's, dementia, progressive memory loss, bipolar disorder or Schizophrenia? ☐ Yes ☐ No

    d) Aneurysm, TIA (mini-strokes)? ☐ Yes ☐ No

    e) Sickle cell anemia, cancer or leukemia? ☐ Yes ☐ No

    f) Multiple Sclerosis, Parkinson's disease, or epilepsy? ☐ Yes ☐ No

    g) Systemic lupus or rheumatoid arthritis? ☐ Yes ☐ No

    h) Hepatitis, liver disease, or bariatric surgery? ☐ Yes ☐ No

    i) Kidney failure or kidney disease? ☐ Yes ☐ No

    j) Chronic joint pain, chronic back pain, arthritis, carpal tunnel, chronic fatigue syndrome, fibromyalgia, osteoporosis, or other musculoskeletal disorders? ☐ Yes ☐ No

Please continue on the next page.

Section 6 – Applicant's Providers

Advance Insurance Company of Kansas (AICK) may contact your health provider(s) for information, or an exam, to determine if you may be covered. List any health care provider you have seen, or consulted with, in the past seven years (including, but not limited to, hospitals, doctors, clinics, chiropractors, physician assistants, or nurse practitioners) in the fields below.

Provider Name

Provider Mailing Address

City

State ZIP Code (_____) _____-_____ Provider Phone Number

_____ /_____ /_____
Approximate Date of Last Visit

Provider Name

Provider Mailing Address

City

State ZIP Code (_____) _____-_____ Provider Phone Number

_____ /_____ /_____
Approximate Date of Last Visit

If you need more space, attach a separate sheet showing each additional providers's name, mailing address, city and state. Print your name and social security number at the top of the page and **sign and date the response.**

Section 7 – Applicant's Prescription Medication

Complete the information below for the prescription medication(s) prescribed to you in the past 7 years.

Prescription medication name & dosage	Approximate Date Prescribed	Physician name, city and state
1.		
2.		
3.		
4.		

If you need more space, attach a separate sheet showing each additional prescription medication's name, dosage, approximate date prescribed and the physician's name, city and state. Print your name and social security number at the top of the page **and sign and date the response**.

Section 8 – Authorization of the Release of Protected Health Information

My signature authorizes any physician, medical practitioner or provider of services, hospital, clinic, pharmacy or other medically related facility, insurance, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition, and any other non-medical information about me to release, disclose and give to Advance Insurance Company of Kansas (AICK), or its reinsurers, a complete copy of any and all such information.

I understand the information obtained by use of this Authorization will be used by AICK to determine eligibility for insurance and my application for coverage may be delayed or denied if AICK is unable to obtain information necessary to do so.

I understand the information disclosed may no longer be protected and may be re-disclosed without further authorization. Note that AICK will not release information to any person or organization except to reinsurance companies or other persons, or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or further authorized.

I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will be effective to the extent that action has been taken in reliance upon this authorization or AICK otherwise has the right to contest the policy or claims under the policy.

I know I, or my authorized representative, may request to receive a copy of this authorization. I agree a photographic copy of the authorization shall be as valid as the original. I agree this authorization shall be valid for 24 months from the date shown below.

Your signature required

Applicant _____ /_____ /_____ Date Signed

Print Name _____ /_____ /_____ Applicant's Date of Birth

Please continue on the next page.

Section 9 – Limitations

I understand the following limitations apply to this AdvanceCare Short Term Disability insurance:

1. Coverage is not provided for a Disability that is caused by, or occurs as a result of, pregnancy or childbirth within the first 10 months after the Effective Date of Coverage.

   Proposed Insured Initials _____

2. Coverage is not provided for a Pre-existing Condition, or re-injuries to a Pre-existing Condition, unless it begins more than 12 months after the Effective Date of Coverage. A Pre-Existing Condition is an illness, disease, infection, disorder, or injury which medical advice, consultation, or treatment was recommended or received, or for which symptoms existed, within the 12-month period before the Effective Date of Coverage.

   Proposed Insured Initials _____

Section 10 – Other Advance Insurance Policies

Do you have any other short term disability insurance coverage with Advance Insurance Company of Kansas (AICK)? ☐ Yes ☐ No

_____ _____
If yes, amount Name of Policyholder

_____ _____
If yes, amount Name of Policyholder

Section 11 – Choose your payment option

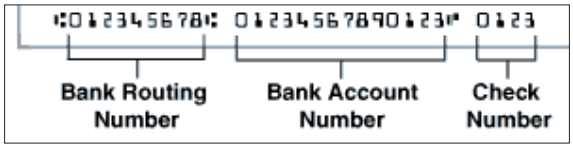
☐ Automatically draft my ☐ Checking ☐ Savings on a ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual basis.

Financial Institution information:

_____
Institution Name

_____
Routing Number

_____
Account Number



By signing, I authorize Advance Insurance Company of Kansas (AICK), an independent licensee of the Blue Cross and Blue Shield Association, to send my premium bill to the above-named financial institution for direct payment for my due premium. By checking this box, I attest that I am the account holder or have been authorized to use the account above. Further, in making this authorization, I agree each monthly payment shall be the same as if it were a document personally signed by me. This authority is to remain in effect until revoked by me in writing. Should any draft entry be dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, AICK agrees the financial institution shall be relieved of any liability.

Your signature required

_____ _____ / _____ / _____
Checking/Savings Account Owner Date Signed

_____
Print Name

☐ Bill me at my mailing address on a ☐ Quarterly ☐ Semi-annual ☐ Annual basis.

Please continue on the next page.

Section 12 – Authorization

I understand I must sign if I am applying for coverage. My signature verifies I have read all the information on this form and represent all statements made herein are complete and true to the best of my knowledge.

I understand Advance Insurance Company of Kansas (AICK) may correct premium, terminate, or rescind the policy: 1) if within two years of the policy effective date my answers are found to be incorrect; or 2) at any time, if the information provided herein intentionally misrepresents a material fact or was fraudulent.

I understand coverage is subject to the health of the Applicant remaining unchanged to the effective date of coverage. AICK's Underwriting Department must be notified of any such change prior to the effective date of coverage at (800) 530-5989.

All persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A.

The insurance being applied for will become effective, subject to the terms and conditions of the policy for which application is made, the first day of the month following being approved at the home office of AICK; an official contract issued and delivered; and the required premium paid and accepted by AICK. If this application is not approved, no insurance will become effective.

The Applicant should not cancel any other coverage until notified by AICK that this application has been approved.

No agent or broker is authorized to bind coverage, approve applications, modify policies or alter or waive any rights or requirements of AICK.

A photographic copy of this authorization shall be as valid as the original.

Your signature required

Signed at _____ (City) State of _____ (State) on ____ / ____ / _____ (Date Signed)

_____
Applicant

_____
Print Name

Thank you for your application. Please send us this form to complete your application.

By mail:
Advance Insurance Company of Kansas (AICK)
P.O. Box 239
Topeka, KS 66601-0239

By fax: 785-290-0727

By email: csc-advance@advanceinsurance.com

Have Questions? Call us in Topeka at 291-4306 or 1-800-641-1019