Loyal American Cancer Addition Instructions – TEXAS

Loyal American Life Insurance Company® is very happy to offer a combination sales opportunity! We created a simplified Cancer Insurance (form LOYAL-FDC-S App) that can be used with a Medicare Supplement Policy at point of sale. Please make sure to review the qualification criteria for the cancer coverage to ensure eligibility. Simply follow the instructions below according to your method of Medicare Supplement application submittal.

If Submitting a Medicare Supplement Application via Express App

Complete and submit the Medicare Supplement application in the normal manner through Express App. Review the Loyal American Cancer Insurance application with the client.

Face-to-Face Sales - If your client wishes to add the cancer coverage you can complete the Cancer Insurance application for the client and have your client sign on the applicant's signature line.

Phone Sales – Carefully cover all areas of the Cancer Insurance application and complete all required information. Write "Phone Sale" on the applicant's signature line. Request a "Combo" (Medicare Supplement and Cancer) Phone Verification to ensure the proper interview is conducted.

Take the completed Cancer Insurance application and return to us with the Replacement Form (if required) and the completed Fax App Cover Sheet (CSB-9-0009) and write "Express App" in the upper, right corner. You must submit the Cancer Insurance Application *with the Fax App sheet* within 24 hours of the submitted Medicare Supplement Express App to ensure proper processing. Be sure to check the "☐ Combo" box to alert our staff to match the Cancer Insurance Application with your Medicare Supplement Insurance Application submitted via Express App. The Fax App Cover sheet contains our mailing address and fax number for submission, or you can email to: CSBNewBusiness@Cigna.com

.

If Submitting a Medicare Supplement Application via Paper

Complete and submit the Medicare Supplement application in the normal manner. Review the Loyal American Cancer Insurance application with the client.

Face-to-Face Sales - If your client wishes to add the cancer coverage you can complete the Insurance application for the client and have your client sign on the applicant's signature line.

Phone Sales – Carefully cover all areas of the Cancer Insurance application and complete all required information. Write "Phone Sale" on the applicant's signature line. Request a "Combo" (Medicare Supplement and Cancer) Phone Verification to ensure the proper interview is conducted.

Submit the completed Cancer Insurance application and return to us with the Replacement Form (if required and the completed Fax App Cover Sheet (CSB-9-0009) in your normal manner, i.e. fax or mail. You must submit the Medicare Supplement Application and Cancer Insurance application with the Fax App sheet to ensure proper processing. Be sure to check the "☐ Combo" box to alert our staff to match the Insurance application with your Medicare Supplement application.

* The Loyal American Cancer Insurance application is for adding the cancer coverage only. Agents wishing to add any other options or riders to the cancer coverage must use the full cancer product application and applicable marketing material.

Loyal American Life Insurance Company®

PV Case # _____

P.O. Box 559015, Austin, TX 78755-9015

Cancer Insurance Addition

(Not valid for tobacco users or if you are applying for a Medicare Supplement policy during an open enrollment period or on a Guaranteed Issue basis.)

Upon issue of your Medicare Supplement policy, you may qualify for a $5,000 First Diagnosis Cancer Insurance Policy if you can answer "No" to three additional questions. You may add this important coverage by simply completing and returning this form to the company with your Medicare Supplement application.

HEALTH QUESTIONS *(If the answer to any question in this section is YES, the applicant is not eligible for coverage.)*

		Yes	No
1.	Have you ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
2.	Have you ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
3.	Have you ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

Monthly bank draft rates for $5,000 of supplemental First Diagnosis Cancer protection:

Issue Ages	Female Rates	Male Rates
65-69	$11.60	$16.19
70-74	$13.52	$19.81
75-80	$14.75	$21.72

The billing frequency for your First Diagnosis Cancer Policy will match your Medicare Supplement Policy. The above rates shown are monthly bank draft rates. Consult our rate chart for other billing frequencies.

Med Supp billing frequency: ☐Monthly ☐Quarterly ☐Semi-Annual ☐Annual

First Diagnosis Cancer Policy Modal Premium $_____

Is the Insurance applied for here intended to replace any existing or pending Cancer insurance? ☐Yes ☐No

If yes, list the Company and Policy Number:_____
and complete the applicable replacement form.

I acknowledge and agree that Loyal's issuance of this cancer insurance policy is reliant upon the information contained above and in the application I completed for my Loyal American Medicare Supplement policy which shall become a part of the cancer insurance policy I am purchasing, and any misstatement of material facts contained in either application may result in the rescission of this cancer insurance policy. I understand and agree that (1) there will be no coverage until my application is approved by the Company; (2) the initial premium has been paid; (3) this form and Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance, if applicable, are received at the Home Office; and (4) the policy has been issued by the Company. I understand and agree that: (1) No agent has the authority to waive the answer to any questions on the application; (2) No applicant is covered by any Title XIX program (Medicaid or any similar name.); and (3) I have received the Outline of Coverage for the policy applied for, the replacement notice form if applicable the required Guide to Health Insurance for People with Medicare. THIS POLICY IS A FIRST DIAGNOSIS CANCER ONLY POLICY. I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I now have, or have had in the past twelve (12) months.

By signing below, I hereby request that Loyal issue a First Diagnosis Cancer Insurance Policy form number series LY-FDC-BA. I understand my bank account will be drafted for the additional premium and my effective date will be the same as my Medicare Supplement policy.

Applicant's Printed Name	Signature of Applicant	Date
Agent's Printed Name	Signature of Agent	Writing Number

Loyal American Life Insurance Company®
P.O. Box 559015, Austin, TX 78755-9015
Toll Free: 800-633-6752

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Loyal American Life Insurance Company®
P.O. Box 559015, Austin, TX 78755-9015
Toll Free: 800-633-6752

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Loyal American
Life Insurance Company®
P.O. Box 559015, Austin, TX 78755-9015
Toll Free: 800-633-6752

OUTLINE OF COVERAGE FOR FIRST DIAGNOSIS CANCER INSURANCE POLICY FORM LY-FDC-BA-TX

SPECIFIED DISEASE COVERAGE
THIS POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If an Insured Person is eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

1. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

2. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.

3. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

4. ***BENEFITS PROVIDED BY THE POLICY***

   FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician, We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

   If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

1. 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
2. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

1. the Date of Diagnosis shall occur while the Insured Person is covered by this policy; and
2. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of this policy. The reduced Benefit Amount for Cancer will be 10% of the First

Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this policy's Effective Date, coverage for the Insured Person under the this policy will end.

5. EXCLUSIONS AND LIMITATIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy:

1. for any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
2. loss that begins prior to the Effective Date of coverage; or
3. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

6. TERMS UNDER WHICH THIS POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive riders on it without Your permission.

7. YOUR TOTAL ANNUAL PREMIUM (At time of application):

	Tobacco	Gender	Age	FDC Policy
SELF	☐Y / ☐N	☐M / ☐F		
SPOUSE	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
CHILD	☐Y / ☐N	☐M / ☐F		
TOTAL ANNUAL PREMIUM				$

(Please attach a separate sheet if needed)

LOYAL AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 559015 ● Austin, Texas 78755-9015

SPECIFIED CRITICAL ILLNESS INSURANCE
MEDICARE DUPLICATION NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specified diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program.

New Business Submission Form/FaxApp

To: Cigna Supplemental Benefits **Fax #: 877-704-8186**

AGENT'S INFORMATION (Must be Completed)

FROM:	
PHONE #:	**FAX #:**
WRITING #:	**EMAIL:**
DATE:	**NUMBER OF PAGES:** + cover

APPLICANT'S INFORMATION (Must be Completed)

NAME:	**SS#:**	☐ Combo ☐ CWA ☐ Draft
NAME:	**SS#:**	☐ Combo ☐ CWA ☐ Draft
NAME:	**SS#:**	☐ Combo ☐ CWA ☐ Draft
NAME:	**SS#:**	☐ Combo ☐ CWA ☐ Draft
NAME:	**SS#:**	☐ Combo ☐ CWA ☐ Draft

All applications submitted with a single cover sheet must be from the same writing agent.

Procedures:

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.** Simply complete the application and fax the following to **877-704-8186**.

- FaxApp Cover Sheet
- Application in numeric page order
- Any state specific or replacement forms where applicable
- **Copy of the initial premium check if collected from the client at Point-of-Sale or a voided check so that we can draft for the initial premium. You must submit one or the other or the application cannot be processed.**
- **Medicare Supplement Open Enrollment and Guarantee Issue cases are not eligible for the FaxApp Program. You must mail the completed application with a check for first month's premium to the Imaging-New Business address below.**

Premium:

- Agents are encouraged to utilize the bank draft authorization to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant **please indicate the case number on the check** and mail the check, stapled to the top of the FaxApp cover sheet, to:

Imaging-New Business
P.O. Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the contract must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating the contract will be cancelled in 5 days unless we receive payment for the issued contract. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the contract has been cancelled due to non-payment of premium.**

Cigna®