GROUP CANCER PROTECTION INSURANCE APPLICATION

Policy Number: MZ0100313H0037A (Enhanced Option)
Policy Number: MZ0800577 0038A (Standard Option)

Name_______________________________________ Birth Date (MM/DD/YY): ____/____/____

Address_______________________________________ Gender: ❑ Male ❑ Female

City/State/Zip_______________________________________ Social Security No. ____________________

Are you or any dependents eligible for Medicare? ❑ Yes ❑ No
If, in addition to yourself, you are applying for family coverage, complete below as applicable:

Name **Date of Birth**

Spouse ______________________________ (MM/DD/YY):____/____/____ Social Security No.____________________

Child: ______________________________ (MM/DD/YY):____/____/____

Child: ______________________________ (MM/DD/YY):____/____/____

If more than two children are proposed for insurance, please attach a separate sheet.

Monthly Rates:

COVERAGE OPTION	ENHANCED OPTION PLAN	STANDARD OPTION PLAN
❑ Member	$10.25	$6.95
❑ Family	$19.16	$13.00

Method of Payment:
A $.50 per month administrative fee will be added to your bill.

❑ **Annual** Premium Enclosed: $________________

❑ **Monthly** Automatic Checking or Savings Account Deduction Only.
(Be sure to complete the enclosed Automatic Payment Option Form and return it with your application.)

To the best of your knowledge and belief, have you or your dependents (if applying for dependent(s) coverage) ever received treatment or have been medically advised of Cancer, Leukemia, or Hodgkin's Disease during the last 5 years (12 months in Texas)? ....❑ Yes ❑ No
Treatment means medical and surgical care by a licensed provider to detect or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to monitor a previous removal or remedy of Cancer, provided there is no positive diagnosis of Cancer or of a recurrence of Cancer.

If you have answered "Yes," please indicate name(s) of the person(s) and their corresponding medical condition(s): ____________________________
____

It is understood that any person listed will not be eligible for coverage except any person listed with Skin Cancer. Any person listed with Skin Cancer will be eligible for coverage. It is understood that no benefits will be payable for expenses incurred during the first 12 months of coverage for any cancer diagnosed or treated within the first 30 days after the insured person's effective date of coverage (not applicable to residents of AZ, MN, MO, TX, UT, VT, WI, and WY). Your coverage will be effective on the first day of the month following acceptance of your application, provided your first premium is paid and you are not hospital-confined on that date. I acknowledge that I have received, read and understand the Insurance Disclosures on the reverse side of this form where applicable.
UTAH RESIDENTS: It is understood that no person to be covered for cancer is also covered by any Title XIX program, designated as Medicaid or any similar name. CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

X____
Signature of Applicant Date
X____
Signature of Spouse (if applying) Date
X____
Signature of L.R.A. (where required by law) Date

CA1000GEM(4/95), CA1000GEM.CA(4/95), CA1000GEM.MO(10/95), (TX), CA1000GEM.UT(4/95) 11298-6/99(A/T)

PREMIUM PAYMENT FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY MONUMENTAL LIFE INSURANCE COMPANY

To apply, please complete this form in ink, sign, date and return it with your first modal premium check made payable to Selman & Company:

ACerS MEMBERS' INSURANCE PROGRAM • 6110 Parkland Boulevard • Cleveland, OH 44124

FL RESIDENTS
Any person who, knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PA RESIDENTS
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AR, CO, DC, KY, LA, ME, NM, OH, OK and TN RESIDENTS
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
This policy or certificate duplicates some Medicare Benefits

THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY

This policy or certificate provides limited benefits, if you meet the policy conditions, for hospital and medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy or certificate. It does not pay your Medicare deductibles or coinsurance and is not a substitute for a Medicare supplement insurance policy.

This policy or certificate duplicates Medicare benefits when it pays hospital or medical expenses up to the maximum stated in the policy. Medicare generally pays for most or all of these expenses.

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

- Hospitalization
- Physician services
- Hospice
- Other approved items and services

BEFORE YOU BUY THIS POLICY:
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 insurance, contact your state insurance department or state senior insurance counseling program.

Automatic Payment Option (APO)
Savings or Checking Account Deduction Authorization Form

1. Applicant's Information *(proposed insured)*

Applicant's Name ______________________ Date of Birth ____/____/____

Street Address ______________________

City ______________________ State______ Zip Code ______________

Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:

Policy Number: ______________________ Type of Insurance: ______________________

2. Financial Institution Information

Depositor Name (Payor)______________________
(As it appears on Financial Institution Records)

Financial Institution Name ______________________ Account Number ______________________
(Include Branch Name)

Financial Institution City______________________ State______ Zip Code______________

3. Account Selection: I authorize an automatic deduction from my *(please choose one)*:

❒ **Checking Account.** Attach a sample VOIDED check.

❒ **Savings Account.** Account Number: ______________________ Routing Number: ______________________

Premium deduction should be made:
❒ **Monthly** ❒ **Quarterly** ❒ **Semi-Annually** ❒ **Annually**

Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.

4. Signature/Authorization

In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard ,Cleveland, OH 44124-4187.

Signature of **Depositor** ______________________

Print Name of **Depositor** ______________________ **Date** ____/____/____

Signature of **Applicant/Insured** *(If different from Depositor)* ______________________

Print Name of **Insured/Applicant** ______________________ **Date** ____/____/____

5. Agreements & Conditions

Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of $15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

OFFICE USE ONLY Insured ID: ______________________ APO Effective Date: ______________