

**Application to WESTWARD LIFE INSURANCE COMPANY, Lakewood, CA  
For Hospital Confinement Indemnity Coverage under Group Policy Form WLIC-HIP-O3 MGP**

1. Name of Association: \_\_\_\_\_

2. Name of Member/Applicant: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
(month) (day) (year)

3. Home Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
(number & street) (city) (state) (zip code) (area code) (number)

Mailing or Billing Address (if other than Home Address): \_\_\_\_\_  
(street-apt no.-P.O. box) (city) (state) (zip code)

4. Dependents Coverage: I wish to apply for coverage for my following dependents:

First and Middle Name	Date of Birth	Age	Sex	Ht	Wt	SSN	Relationship

5. Benefit Being Applied For:

Daily Hospital Confinement Benefits ..... \$ \_\_\_\_\_  
 Daily Intensive Care/Coronary Care Unit Confinement Benefits..... \$ \_\_\_\_\_  
 Maximum Emergency Accident Treatment Benefits ..... \$ \_\_\_\_\_  
 Maximum Ambulance Transportation Benefits ..... \$ \_\_\_\_\_  
 Surgical Benefits – Unit Values ..... \$ \_\_\_\_\_

6. To qualify for coverage, you must answer the following questions:

- a. Are you now, or within the past 24 months have you been: (a) confined to a hospital, nursing home or other medical institution; (b) receiving home health care services or kidney dialysis; or (c) medically diagnosed as having, or are you receiving or been advised by a doctor to seek, care and/or treatment for internal cancer, melanoma, Alzheimer's, systemic lupus, uncontrolled diabetes or high blood pressure, or congestive heart failure? .....  Yes  No
- b. Have you been medically diagnosed as, or are you receiving or been advised by a doctor to seek care and/or treatment for being HIV-positive, or having AIDS or AIDS-related complex? .....  Yes  No
- c. Please give details to any "Yes" answers, specifying condition, dates, treatment received and/or recommended and current status: \_\_\_\_\_

\_\_\_\_\_ (Attach additional signed & dated sheet if more room needed.)

7. Other Coverage:

- a. Do you now have comprehensive benefits under a health insurance policy or health maintenance organization (HMO) plan? .....  Yes  No  
 If "Yes," Please list Company name, Type of Coverage and Benefits: \_\_\_\_\_

**Please Note:** Applicants who do not have comprehensive benefits under a health insurance policy or health maintenance organization (HMO) plan will not be eligible for this policy.

- b. Will any existing coverage be replaced by the coverage you are applying for? .....  Yes  No  
 If "Yes," please give company name, type of coverage and policy number: \_\_\_\_\_

**Warning:** Failure to disclose existing coverage, your intentions to replace such coverage, or the existence of coverage terminated within 30 days of this application may result in the denial of a claim or the rescinding of your coverage under the policy for which you are applying.

**PLEASE COMPLETE APPLICATION ON BACK SIDE**

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8. Premium: Insurance Coverage \$ \_\_\_\_\_  
Administrative Fee \$ \_\_\_\_\_  
TOTAL PAYMENT DUE \$ \_\_\_\_\_

Please make check/money order payable to:  
Westward Life Insurance Company

Payment Mode:  Annual  Semi-Annual  Quarterly  Monthly ]

Billing Method:  Direct Bill  Bank Draft  Payroll ]

I HEREBY APPLY for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the questions contained in this application are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be granted solely and entirely in reliance upon my answers to the questions contained in this application; (2) no coverage will exist until a Certificate of Coverage is issued, and will be in force only as of the Certificate Effective Date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss because of a pre-existing condition will not be covered until my coverage has been in force for 12 months.

**WARNING:** 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 may subject such person to criminal and civil penalties.

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

Signature of Applicant: \_\_\_\_\_

[ I hereby certify that I personally saw the applicant and truly and accurately recorded the above information.

Agent's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ Agent's Number(s): \_\_\_\_\_ ]