Reserve National INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

GENERAL A&H APPLICATION

NAME OF PLAN _____

AGENT CODE _____ MGR CODE _____

FOR HOME OFFICE USE ONLY

POLICY NUMBER _____ EFFECTIVE DATE: Month _____ Day _____ Year _____

SERC GRC IRC CHS OS ONLY

Percent of Coverage %	Deductible $	OS Policy Yr. Max. $	Daily Room Max. $	Surgery Units/Max.	Hosp. Misc. Max. $

DCI

Daily Indemnity Amount: $	Post-Hosp. Daily Amt: $

COMPLETE A SEPARATE APPLICATION FOR EACH POLICY

1. Full Name of Each Applicant

	First	Middle Initial	Last	Social Security No.	Relation To Applicant	BIRTH DATE Mo.	Day	Yr.	Age	Height	Weight	Sex	Basic	List Endorsements and Rates					PEB Table	Total Monthly Prem.
1					Applicant															
2																				
3																				
4																				
5																				

2. Residence of Insured _____
Street No. / Rural Route and/or Box Number — City — State — Zip Code

3. Residence Telephone No. area code (____) No: _____ Business area code (____)No: _____

4.(a) Applicant's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____

5. Full Name of Beneficiary(ies) _____ Relationship _____

Without a Beneficiary Designation any benefits which are not assigned at the death of an insured shall be paid to the applicant first named above if living, otherwise to the estate of the deceased.

6. If submitted for purposes other than a new insurance application, please indicate: ☐ Policy Change ☐ Conversion ☐ Reinstatement: Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

THE FOLLOWING QUESTIONS, #7 - #41, ARE TO BE ANSWERED WITH RESPECT TO EACH APPLICANT LISTED ABOVE.

7. If this application is for a Medicare supplement, are applicant(s) enrolled in Medicare Part A? ☐ **Yes** ☐ **No** Part B? ☐ **Yes** ☐ **No** If no, which applicant(s)? _____

8. Do any of the above-named applicants have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application? ☐ **Yes** ☐ **No** If yes, give details. _____

9. Do you intend the replacement or change of any of your existing insurance policy(ies) in connection with this application for insurance? ☐ **Yes** ☐ **No** If yes, state company and amount and complete replacement of insurance form. _____

10. SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS A SCHEDULED BENEFIT POLICY WITH LIMITS FOR EACH COVERED EXPENSE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE THERE ARE LIMITATIONS ON THE AMOUNT OF BENEFITS PAYABLE FOR EACH COVERED EXPENSE.

_____
Signature

11. Has any applicant smoked tobacco or used tobacco orally within the past year? ☐ **Yes** ☐ **No** If yes, which applicant(s)? _____

12. Is any applicant using any medication or drugs? ☐ **Yes** ☐ **No** If yes, which applicant(s)? Details? _____

13. Does any applicant participate or contemplate participating in any type of private aviation? ☐ **Yes** ☐ **No** If yes, give details. _____

14. Has any applicant within the past 5 years participated in or do you contemplate participating in **professional or semi-professional athletics, racing (automobile, snowmobile, motorcycle, boat or go-kart), scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning or para sailing, hockey or football, wrestling or boxing?**
☐ **Yes** ☐ **No** Which applicant(s)? Details? _____

15. Has any applicant ever had life, disability or health insurance declined, rated, modified, cancelled or not renewed? ☐ **Yes** ☐ **No** Which applicant(s)? Details? _____

16. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability? ☐ **Yes** ☐ **No** Which applicant(s)? Details? _____

If application is accepted by the Company the applicant requests coverage to be effective: A. ☐ **Date of application, applicable only on quarterly or longer modes.**

B. ☐ **Date of issue** **C.** ☐ **Other** _____ ☐ **SEND POLICY TO APPLICANT** ☐ **OR AGENT TO DELIVER.**

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR CONSULTED OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

17. Disorder of eyes, ears, nose, throat or glands? ☐ Yes ☐ No
18. Dizzy or fainting spells, seizures or convulsions or recurrent headache? ☐ Yes ☐ No
19. Paralysis or stroke? ☐ Yes ☐ No
20. Mental, nervous or psychiatric disorder? ☐ Yes ☐ No
21. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, emphysema, tuberculosis, pneumonia or other lung or respiratory disorder(s)? ☐ Yes ☐ No
22. Chest pain, discomfort or tightness, any heartbeat abnormality, rheumatic fever, heart murmur, heart attack or other disorder of the heart? ☐ Yes ☐ No
23. Hypertension, high blood pressure or disorder of blood vessels? ☐ Yes ☐ No
24. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver, gall bladder, pancreas or hemorrhoids? ☐ Yes ☐ No
25. Sugar, albumin, blood in urine, stone or other disorder of kidney, bladder, prostate or reproductive organs? ☐ Yes ☐ No
26. Diabetes, thyroid or other endocrine disorders? ☐ Yes ☐ No
27. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, spine, back or joints? ☐ Yes ☐ No
28. Deformity, lameness or amputation? ☐ Yes ☐ No
29. Disorder of the skin or lymph glands, unexplained fevers, cyst, tumor, cancer or malignant neoplasm? ☐ Yes ☐ No
30. Allergies, anemia or other disorder of the blood? ☐ Yes ☐ No
31. Have you ever been treated for or ever had any known indications of AIDS, ARC (AIDS Related Complex), an immune deficiency disorder or HIV blood test or test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

32. Any sexually transmitted disease including syphilis, gonorrhea, herpes, chlamydia, condyloma acuminata (anal or genital warts)? ☐ Yes ☐ No
33. Has any applicant sought or received advice or treatment for use of alcohol or drugs? ☐ Yes ☐ No
34. Has any female ever had any disorder or complications of menstruation, pregnancy, childbirth, the female organs or breasts? ☐ Yes ☐ No
35. Is any applicant now pregnant? ☐ Yes ☐ No
36. Other than above, has any applicant been examined, advised or treated by any physician or practitioner? ☐ Yes ☐ No
37. Has any applicant been a patient in a hospital, clinic, psychiatric clinic or medical facility? ☐ Yes ☐ No
38. Has any applicant ever had an EKG, X-ray, CT scan, MRI or other test? ☐ Yes ☐ No
39. Has any applicant lost or gained weight in the past 12 months? ☐ Yes ☐ No
If yes, state amount and cause of loss or gain and indicate which applicant(s)_____

40. Has any applicant been advised **not** to donate or been refused to donate blood? ☐ Yes ☐ No
If yes, explain why and by whom in Remarks.

41. Other than above, has any applicant had any mental or physical disorder, checkup, consultation, illness, injury, surgery, been a patient in a hospital, clinic, sanatorium or other similar facility or been advised to have any diagnostical hospitalization, or surgery which was not completed or had any departures from good health not mentioned above? ☐ Yes ☐ No
If yes, give full details in Remarks in Question #42 below.

FOR HOME OFFICE USE

42. EXPLAIN BELOW MEDICAL QUESTIONS ANSWERED "YES" FOR QUESTIONS 17–41. (Attach additional page(s) if needed.)

Applicant No.	Disease or Ailment	Treatment Received	Dates Treated For	Present Status of Ailment	Full Name and Address of Attending Physician

Personal Physician_____ Medical Designation_____ Phone Number (____) _____

Address_____ City_____ State_____ Zip Code_____

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have sixty days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National, **I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates; and (b) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. NOTICE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.**

I have paid to _____ the sum of $_____ which is a ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual premium, and I hold receipt for the same made up without alteration bearing the same date as this application. **I acknowledge receipt of an outline of coverage for which this application is made ☐ Yes ☐ No. I am 65 years old or older, or eligible for Medicare, and acknowledge receipt of a "Guide to Health Insurance for People with Medicare" ☐ Yes ☐ No.**

Town and State where signed_____ **this**_____ **day of**_____, _____.

_____ Signature of Owner (if other than Proposed Insured)

_____ Signature of Proposed Insured or Applicant

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____ Signature of Agent