# Fax cover sheet

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

• Indicate intended recipient below.

☐ **Pages** (including cover)

**To:** *(check one)*

◯ **New application submission**

*(Use only for the original submission of the New Business application packet)*

Fax: **877-380-2777**

◯ Follow up documentation requested

*(Use when sending additional information/pages for an existing New Business policy submission or if requested by a case manager.)*

Attn: Fax: 855-447-0391

◯ Underwriting information requested

*(Use after new application submission only if contacted by Underwriting for additional information)*

Attn: Fax: 855-411-9633

**From** • **Email** •

**Phone** • **Fax** • **Date** •

**I have included the following:**

◯ Application ◯ Transmittal form ◯ Bank draft requirements ◯ Other required forms ◯ Trailing documentation

**Applicant name** • **Policy number** •

**Comments**

Due to HIPAA privacy of information, faxed responses will not include the name of a policyholder or applicant but, when appropriate, will reference the policy/application tracking number. Information will only be provided if your inquiry pertains to policyholders or applications for which you are either the writing agent or otherwise associated with the policy or application for coverage.



CVS Health®

# Application for
# **Individual Whole Life Insurance**

## Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

Policy administered by Aetna Life Insurance Company and its affiliates

## Florida



CVS Health®

# Application for Individual Whole Life Insurance



- *Print clearly and use blue or black ink.*
- *Use section 7 for additional remarks, requests, or explanations.*
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512**.

## Section 1. Proposed insured information

**Proposed insured's name** *(first, M.I., last)*

**Phone**

**Residential address** *(must be a physical address)*

**Apt/suite number**

**City** | **State** | **Zip**

**Mailing address** *(if different than residential address)*

**Apt/suite number**

**City** | **State** | **Zip**

**E-mail** | **Social Security Number** | **Birth date*** *(mm/dd/yyyy)*

**Place of birth** | **Age** | ☐ **Male** ☐ **Female**

**Are you a legal resident of the United States?** ☐ Yes ☐ No

**Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)** ☐ Yes ☐ No

**Do you have an existing Medicare Supplement policy with Aetna?** ☐ Yes ☐ No

**If Yes, what is your policy number?**

## Section 2. Health questions

For the purposes of these questions "you" means the proposed insured. "Diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. "Terminal condition" means an illness, disease or disorder which would reasonably be expected to cause death within 12 months.

**Part A -** If you answer "yes" in part A, you are not eligible. Do not complete or submit this application.

**1. Are you currently:**

**A.** confined in or been advised to enter a hospital, nursing home, skilled nursing facility, psychiatric facility, correctional facility? ☐ Yes ☐ No

**B.** receiving or been advised to receive home health care or hospice care? ☐ Yes ☐ No

**2. Do you use a wheelchair or mobility scooter or do you have any physical or mental impairment requiring assistance from anyone with the following activities of daily living: taking medications, bathing, dressing, eating, toileting, getting in or out of bed or chair, or moving about?** ☐ Yes ☐ No

**3. Within the past year have you:**

**A.** used or been advised to use oxygen equipment to assist with breathing (excluding CPAP for sleep apnea) or had or been advised to have kidney dialysis? ☐ Yes ☐ No

**B.** been advised to have any medical procedure, surgery or a diagnostic test which has not yet been started, completed, or for which results are not known, excluding tests related to the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

**4. Have you ever received, or been advised to receive, an organ or bone marrow transplant or an amputation due to any disease or complications of diabetes?** ☐ Yes ☐ No

## Section 2. Health questions *continued*

**5. Have you ever been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?** ☐ Yes ☐ No

**6. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:**

**A.** Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Huntington's Disease, or sickle cell anemia? ☐ Yes ☐ No

**B.** Alzheimer's disease, dementia or mental incapacity? ☐ Yes ☐ No

**C.** congestive heart failure, pulmonary fibrosis, any terminal condition or end-stage disease? ☐ Yes ☐ No

**D.** cerebral palsy, cystic fibrosis, muscular dystrophy or un-operated heart defects? ☐ Yes ☐ No

**7. Within the past 2 years have you been diagnosed with, received or been advised to receive chemotherapy or radiation for any form of cancer (excluding Basal or Squamous cell skin cancer)?** ☐ Yes ☐ No

**8. Have you ever been diagnosed with more than one occurrence of the same or different type of cancer?** ☐ Yes ☐ No

**Part B -** If any "yes" answers in part B, select ***Modified Plan***.

**1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment or medication for:**

**A.** alcohol or drug abuse (prescribed or illegal), or used illegal drugs; or been convicted of or plead guilty to driving under the influence? ☐ Yes ☐ No

**B.** complications of diabetes such as diabetic coma, insulin shock, retinopathy (eye disorder), nephropathy (kidney disorder), or neuropathy (nerve, circulatory disorder)? ☐ Yes ☐ No

**C.** kidney or liver disease? ☐ Yes ☐ No

**2. Within the past year have you been diagnosed with, received or been advised to receive treatment for:**

**A.** angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? ☐ Yes ☐ No

**B.** stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? ☐ Yes ☐ No

**Part C -** If any "yes" answers in part C, select ***Standard Level Plan***.
If all "no" answers in Parts A, B and C select ***Preferred Level Plan***.

**1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment for:**

**A.** angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? ☐ Yes ☐ No

**B.** stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? ☐ Yes ☐ No

**2. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:**

**A.** Parkinson's disease, Multiple Sclerosis or Systemic Lupus (SLE)? ☐ Yes ☐ No

**B.** chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema or any other chronic respiratory condition? ☐ Yes ☐ No

## Section 3. Benefits and premium information

**Initial amount of insurance applied for**
$

**Plan requested**
☐ Preferred Level Plan ☐ Standard Level Plan ☐ Modified Plan

**Riders requested** *(not available with Modified Plan)*
☐ Accidental Death Benefit Rider ☐ Accelerated Death Benefits Rider ☐ Children's Term Insurance Rider

**Requested effective date*** *(mm/dd/yyyy)*
.

**Nonforfeiture options****
☐ Automatic premium loan ☐ Paid-up insurance ☐ Extended term insurance

**Initial premium**

☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

I would like subsequent payment withdrawn on the ____day of the month **OR** the ☐ 2nd ☐ 3rd ☐ 4th Wednesday of the month.

**Initial premium amount**
$

**Payment mode**
☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

**Initial premium method**
☐ EFT *(Electronic Funds Transfer)* ☐ Check or money order

**The insurance for which you qualify may have a return of premium death benefit for the first two (2) years. The amount of coverage applied for may be less than the amount approved and not all riders are available on all plans.**

☐ Check here if you are willing to accept any plan shown above.

**Which do you prefer?**

☐ Adjust the face amount to match the premium ☐ Keep the same amount of insurance and adjust the premium

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.

**If a nonforfeiture option is not selected, extended term insurance is the default.

**Mail policy to:** ☐ Applicant ☐ Agent

**Payment modes**
You have a choice of four payment modes for paying your premium. The Company may charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

## Section 4. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. Percent share must total 100%.

**Primary beneficiary name** *(first, M.I., last)*
.

**Relationship to insured**
.

**Phone**
.

**Share**
. %

**Address**
.

**Social Security Number**
.

**Primary beneficiary name** *(first, M.I., last)*
.

**Relationship to insured**
.

**Phone**
.

**Share**
. %

**Address**
.

**Social Security Number**
.

## Section 4. Beneficiary *continued*

**Contingent beneficiary name** *(first, M.I., last)* | **Relationship to insured** | **Phone** | **Share**

. . . . %

**Address** | **Social Security Number**

. .

**Contingent beneficiary name** *(first, M.I., last)* | **Relationship to insured** | **Phone** | **Share**

. . . . %

**Address** | **Social Security Number**

. .

## Section 5. Replacement information

**1. Does the proposed insured currently have any life insurance or annuity in force?** ☐ Yes ☐ No

**2. Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force?** ☐ Yes ☐ No

If the answer to either question is “yes”, please provide the information below:

**Company name** | **Face amount** | **Policy number**

. . .

**Company mailing address** *(to send notice of replacement)*

.

## Section 6. Health history optional comments *(not required)*

**Provide any additional information available regarding underwriting questions (diagnosis, dates, durations, medications, dosages).**

## Section 7. Remarks

## Section 8. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by taking your insurance application, collecting your initial premium and, if applicable, delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- commissions when a policy is purchased or renewed
- fees for marketing and administrative services
- educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

## Section 9. Applicant agreement

This agreement is to acknowledge that I am applying for an insurance policy from Accendo Insurance Company that will be issued based on my answers to the questions on this application and information obtained by the company as described below. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the company's administrative office, and made a part of the contract of insurance. An officer of the company is the only one who can make, modify or discharge contracts or waive any of the company's rights or requirements. Any modifications must be documented in writing.

I also understand that, unless otherwise specified in the Conditional Receipt, I do not have coverage until this application is approved, the first full modal premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the company and coverage has become effective.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand and agree that information regarding my insurability will be treated as confidential. Accendo Insurance Company or its reinsurers may, however, make a brief report of my protected health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. I understand and agree that if I apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. I may contact MIB at 866-692-6901. If I question the accuracy of information in MIB's file, I may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, consumer reporting agency, pharmacy, pharmacy benefit manager, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Accendo Insurance Company, or its reinsurers, any such information.

This authorization shall remain valid for 24 months, and I understand I may revoke this authorization at any time. I understand that a revocation is not effective to the extent that any person or entity has already relied on this authorization to disclose or use information about me or to the extent that Accendo Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

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

| **Applicant signature** | **Date signed** |
|---|---|
| **X** | . |
| **Owner signature*** *(if not proposed insured)* | **Date signed** |
| **X** | . |
| **Owner Social Security Number** | **Signed in** *(city and state)* |
| . | . |

*If owner or payor is different than proposed insured, indicate name, address and relationship to proposed insured in Remarks (section 7).

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.

## Section 9. Applicant agreement *continued*

I understand that I have the right to designate one person other than myself to receive notice of the impending termination of this contract because of nonpayment of premium.

☐ I elect not to designate anyone to receive such notice.

☐ I designate the following person to receive such notice prior to cancellation of my contract for nonpayment of premium.

**Full name of designated person** *(first, M.I., last)*

**Residential address** *(must be a physical address)* | **Apt/suite number**

**City** | **State** | **Zip**

## Section 10. Bank account information

Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment. Include a voided check with the application.

**Account owner name** *(if different than proposed insured's)*

**Account owner relationship to proposed insured**

☐ Family member; please specify: .....

☐ Living trust ☐ Employer ☐ Power of Attorney ☐ Conservator/guardian ☐ Business owned by proposed insured

**Financial institution name** | **Account type**

☐ Checking ☐ Savings

**Routing number** | **Account number**

☐☐☐☐☐☐☐☐☐ | ☐☐☐☐☐☐☐☐☐☐☐☐☐

## Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

**Signature only required if** the account owner is different than the proposed insured.

**Account owner signature** | **Date signed**

**X**

## Section 12. Agent information

I certify that:

1. The insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

**Does the proposed insured have any existing life insurance or annuity contracts?** ☐ Yes ☐ No

**Will the policy applied for be a replacement or change existing life insurance or an annuity?** ☐ Yes ☐ No

**If the answer to either question is "yes", have you complied with the requirements of the company and your state regarding this replacement?** ☐ Yes ☐ No

**All information must be completed.** The writing number reflects where commissions will be paid.

**Agent name** *(printed)*

.

**Writing number** *(agent or company)*

.

**Agent signature**

**X**

**Florida license identification number**

.

**Phone**

.

**Email**

.

## Section 13. Agent request to split commissions

If this application results in an issued policy through Accendo Insurance Company (ACC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACC commission schedule.

**Writing agent name** *(printed)*

.

**Percentage**

. %

**Writing agent signature**

**X**

**Florida license identification number**

.

**Secondary agent**

.

**Writing number**

.

**Percentage**

. %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

# Application for Individual Children's Term Insurance Rider

from Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate



- Print clearly using blue or black ink.
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512**.
- Coverage amount selected will be the same for all covered children.
- You can apply for coverage on a maximum of 9 children as defined below. Attach a second application to list more than 5 proposed insured children.
- Coverage amount may not exceed the face amount of the base policy.

**Primary Insured's name**

**Policy number** *(if known)*

**Amount of coverage per child**

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

## 1. Children proposed for insurance

Name natural born children, stepchildren, legally adopted children, grandchildren, legally adopted grandchildren, great grandchildren, proposed for insurance. Insurance will not be provided for newborns less than 30 days of age, children greater than 17 years of age, or children that are not US citizens.

**Proposed Insured's name** | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen** ☐ Yes ☐ No

**Proposed Insured's name** | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen** ☐ Yes ☐ No

**Proposed Insured's name** | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen** ☐ Yes ☐ No

**Proposed Insured's name** | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen** ☐ Yes ☐ No

**Proposed Insured's name** | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen** ☐ Yes ☐ No

## 2. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. If no beneficiary is named for any child, the beneficiary designation defaults to the Insured of the base policy. Attach a separate sheet if necessary.

**Primary beneficiary name** *(first, M.I., last)* | **Phone** | **Share** %

**Address** | **Social Security Number**

**Primary beneficiary name** *(first, M.I., last)* | **Phone** | **Share** %

**Address** | **Social Security Number**

Percent share must total 100%.

**Contingent beneficiary name** *(first, M.I., last)* | **Phone** | **Share** %

**Address** | **Social Security Number**

**Contingent beneficiary name** *(first, M.I., last)* | **Phone** | **Share** %

**Address** | **Social Security Number**

CVSHealth

## 3. Health history

If any of these questions are answered "yes" that child will be excluded from coverage.

**1. Is any Proposed Insured child currently institutionalized or in a care facility?** ☐ Yes ☐ No

**2. Has any Proposed Insured child ever been diagnosed or been treated by a member of the medical profession for: cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs, or been recommended for an organ transplant?** ☐ Yes ☐ No

**3. Has any Proposed Insured child ever been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?** ☐ Yes ☐ No

**4. Has any Proposed Insured child ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines,or other similar drugs except as prescribed by a physician?** ☐ Yes ☐ No

List the children for which "yes" answers were given.

## 4. Acknowledgement

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

**Primary Insured signature** | **City and state where signed** | **Date**

**X** . .

**Agent name** *(printed)* | **Writing number** | **Date**

**X** . .

**Agent signature**

**X**

**Florida license identification number**

.

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.

# Conditional receipt

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate

**No coverage will become effective prior to policy delivery unless and until all conditions of the receipt are met. No agent has the authority to alter the terms or conditions of this agreement.**

All premium checks must be made payable to Accendo Insurance Company. **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.

Received from _____ the sum of **$** _____

by check or preauthorized electronic funds transfer (EFT) as first payment on this application.

**Agent name** .

**Date** .

**If:**

(1) an amount equal to the first full premium is submitted; and
(2) all representations made in the application are true and complete in all material respects; and
(3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under Accendo Insurance Company's rules and practices,

**then insurance under the policy applied for shall become effective on the latest of:**

(1) the date of application, or
(2) the effective date requested in the application.

**The amount of life insurance, including any amount in force or being applied for, which may become effective prior to the delivery of the policy shall in no event exceed $25,000.00. No amount shall be paid under the Accidental Death Benefit Rider or other rider.**

**If any of the above conditions are not met, the liability of Accendo Insurance Company shall be limited to the return of any amount paid.**

**Proposed Insured's name** .

**Proposed Insured signature** X

**Initial payment collected** $

**City and state where signed** .

**Date** .

**Proposed Owner signature** *(if not proposed insured)* X

**Agent signature** X

**Agent number** .

# DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS RIDER

Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate
1021 Reams Fleming Boulevard, Franklin, TN 37064

***(Note: this disclosure only applies where the base policy has a face value of $5000 or greater, in which case the Accelerated Benefits Rider is provided free of any additional premium charge.)***

1. What is an accelerated benefit? An accelerated benefit is a portion of the death benefit paid because the insured is diagnosed as being terminally ill which results in the insured having a life expectancy of twelve months or less.
2. What payment options are available? Up to a maximum of 50% of the face amount if the insured is diagnosed with a terminal illness which results in the insured having a life expectancy of twelve months or less. The minimum benefit that may be requested is $1,000. The maximum benefit that may be requested is $15,000. This amount will be paid as a lump sum. The company may apply a portion of the accelerated death benefit to repay an outstanding policy loan but only up to the amount of the outstanding policy loan multiplied by the percentage of the policy death benefit that has been accelerated. There is an administrative fee of up to $200 to use this benefit.
3. What is the premium for the Accelerated Benefits Rider? No additional premium is charged for an Accelerated Benefits Rider. Policy premiums are still due after taking the accelerated benefit.
4. How will taking an accelerated benefit affect my policy? The cash value, premium, and death benefits will be reduced by the same percentage as the accelerated benefit is to the face amount of the policy. An example is as follows:

| **Values prior to acceleration** | **50% acceleration calculation** | **After receiving 50% acceleration** |
|---|---|---|
| Face amount.....$10,000<br>Premium.....$400<br>Cash value.....$1,000<br>Loan balance.....$200 | **1. Face amount** = $10,000<br>**2. Maximum benefit available:**<br>50% of face amount = $5,000<br>**3. Minus 50% of outstanding loan:**<br>$5,000 – 100 = $4,900<br>**4. Minus administration fee:**<br>$4,900 - $200 = **$4,700**<br>(accelerated benefit amount paid) | Net face amount.....$5,000<br>Premium.....$200<br>Cash value.....$500<br>Loan balance.....$100 |

The net face amount remaining at the insured's death will be paid to the named beneficiary at the insured's death if the policy is in force at that time. Upon a request to accelerate the policy death benefits and upon the payment of the accelerated death benefit, specific information about the effect of an accelerated benefit on policy values, death benefit, premium and loans will be provided to the policyowner and any irrevocable beneficiary. An amended policy schedule page will then be provided to the policyowner to reflect changes in death benefit and policy values as a result of any accelerated benefit payment.

5. Are there any limitations on the use of the accelerated benefit proceeds? There are no restrictions or limitations, except such proceeds may be subject to child support liens.
6. Are the accelerated benefit proceeds taxable? Benefits under this rider are intended to qualify for favorable tax treatment. However, there are circumstances under which these benefits may be taxable. You should consult a personal tax advisor. Receipt of accelerated benefit proceeds may adversely affect the recipient's eligibility for Medicaid or other governmental benefits or entitlements. The accelerated benefit proceeds do not and are not intended to qualify as long-term care insurance.
7. Is the exercise of the rider voluntary? You are not required to exercise the Accelerated Benefit and have the right to waive this benefit.

_____ _____

**Applicant signature** **Date**

_____ _____

**Owner signature** *(if not proposed insured)* **Date**

_____ _____

**Agent signature** **Date**

# Health information authorization

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate



- This is a HIPAA required authorization.
- Please read these statements carefully. Print clearly using blue or black ink.
- Applicant / insured should keep a copy for their records.
- Applicant / insured must submit a completed, signed copy to the home office.
- Policy administered by Aetna Life Insurance Company and its affiliates

## Applicant / insured declarations

I authorize the use and disclosure of health information about me as described below.

**Health Information to be Used or Disclosed:**
I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

**Who May Request or Use Information**: This information may be disclosed to and used and or disclosed by: Aetna and the members of its Affiliated Covered Entity ("Aetna ACE"). An Affiliated Covered Entity is a group of Covered Entities under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Aetna ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the Aetna ACE and as permitted by HIPAA and this authorization; Aetna ACE's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

**Who is Authorized to Disclose Information:** All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

**Purpose:** This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of Aetna's life and health insurance plans.

**Statements of Understanding:** I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to Aetna at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant / insured complete this section.

Signature of applicant / insured

**X**

Date

.

Printed name of applicant / insured

**X**

City

.

State

.

Zip

.

Policy number of insured (if known)

.

ACCMP05970
(012920)



CVS Health®

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

**Accendo Insurance Company**
part of the CVS Health® family of companies and Aetna affiliate
P.O. Box 14399 • Lexington, KY 40512-9700 • 800-264-4000

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ **Yes** ☐ **No**

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

| | | |
|---|---|---|
| **Applicant name** *(print)* | **Applicant signature** | **Date** |
| **Agent name** *(print)* | **Agent signature** | **Date** |

**Agent address**

**Agent company**

Information on Policies which may be replaced:

| Company Name | Policy Number | Name of Insured |
|---|---|---|
| | | |
| | | |

# PRODUCER STATEMENT

## Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate
P.O. Box 14399 Lexington, KY 40512 • 800-264-4000

In connection with a Replacement of Insurance Transaction:
I certify that:

- I have used only Accendo Insurance Company approved sales material
- I have left all sales materials and the Replacement Notice with the applicant, and
- This sale conforms with the company's replacement policy.

The form number(s) of the sales materials left with the applicant are noted below. If no sales materials were used, state "none".

_____ _____

_____ _____

_____ _____

_____ _____
Date Producer's signature

_____
Producer's name

**Replacement policy**

We believe that the replacement of an existing life insurance policy must be appropriate for the customer and must meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is one that is justified from either an economic or personal standpoint. The costs, provisions, features and benefits of both the current and proposed policy should be considered in relation to the customers needs, circumstances and goals.

Some examples of the types of provisions that should be considered are premium rate differences and differences in suicide and incontestability provisions. In addition, factors such as the age and health of the customer must be considered. Producers are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts be provided to the customer when proposing a replacement. Producers are expected to know and comply with these requirements.

# Electronic check authorization

from **Accendo Insurance Company** part of the CVS Health® family of companies and Aetna affiliate



· Print clearly using blue or black ink. · P.O. Box 14399 Lexington, KY 40512-9700

## 1. Usage guidelines

**Requirements:**

- The faxed check method can only be used for **initial premium** payments when the recurring method of payment will be **electronic funds transfer**. This method cannot be used for a one time direct bill quarterly, semi-annual or annual mode.
- The check must be entirely completed. We will not accept faxed checks with missing information such as: pay to, date, written amount, dollar amount, signature, etc.
- The agent will properly destroy the original check once faxed and received at the home office.
- Please submit a copy of the check and this form with your New Business submissions.

## 2. Authorization

Your agent will submit your application for insurance and your initial payment request to the home office via facsimile (fax).

By signing this form, you authorize Accendo to initiate an electronic funds transfer from your bank account according to the terms of the check. This means your check will be converted to an electronic transaction. Your agent will destroy your original check after it is faxed and received at the home office.

I hereby authorize Accendo to draw an electronic funds transfer from my checking account to pay for this insurance policy. **Future premiums for this insurance policy will be deducted from this checking account until you notify us to change your billing.**

Please include any applicable policy fees (per applicant). Make check payable to the appropriate underwriting company.

| **Applicant / account holder signature** *(as it appears on bank records)* | **Date** | **Amount to apply** |
|---|---|---|
| **X** | · | $ |