FREEDOM LIFE™
INSURANCE COMPANY OF AMERICA
a member company of USHEALTH Group, Inc.™

Primary Applicant Information

APP

A. **Primary Applicant Information**

Name _____ Height: _____ Weight: _____
First MI Last
Gender O Male O Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Any form of tobacco or tobacco cessation product in past 12 months? O Yes O No

Resident Address

Address: _____ Home Phone: ( ) _____

City: _____ Business Phone: ( ) _____

State: _____ Zip Code: _____ Cell Phone: ( ) _____

Email: _____ Best time to call: _____

Family Information

B. **Spouse Information**

Name: _____ Height: _____ Weight: _____
First MI Last
Gender O Male O Female

Social Security #: _____ Date of Birth: _____ Birth Place: _____

Employer: _____ Occupation/Duties: _____

Any form of tobacco or tobacco cessation product in past 12 months? O Yes O No

Dependent Information

C. Name: _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

F. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

D. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

G. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

E. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

H. Name _____
First MI Last
O M or O F DOB _____ Ht. _____ Wt. _____

Agent Information

Agent Name: _____ Agent Number: _____
(Please Print)

Coverage Selection

APP

PPO Network _____

Premium Rate Guarantee Period : O 12 Months O 24 months O 36 months
Method of Payment: O Bank Draft O Direct Billing O Credit Card (Initial Payment Only)
Mode of Payment: O Monthly O Quarterly O Semi-Annual O Annual

REQUESTED EFFECTIVE DATE: This effective date request does not guarantee that the application will be approved before the requested date, and thus may not be honored.

O Specific Date / / | O On the next _____ (except 29th, 30th, or 31st) of the month after underwriting decision. | O Date of Application Approval

PRIMARY PLAN

Lifetime Maximum: O $1,000,000 *(MedSaver Plans Only)* O $2,000,000 O $5,000,000

O MedEquity - HSA O MedSaver HSA Plus
Deductible Options:
Individual O $1,200(80% and 60% plan only) O $2,000
O $2,700 O $3,500 O $5,000 (100% Plan Only)
Family O $2,400(80% and 50% plan only) O $4,000
O $5,400 O $7,000 O $10,000 (100% Plan Only)
Coinsurance Options:
O PPO 100% Non-PPO 80%
O PPO 80% Non-PPO 60%
O PPO 60% Non-PPO 60%
Optional Riders:
O Waiver of Premium Rider *(Not available for MedSaver Plus)*
O Maternity Rider O Osteoporosis Benefit Rider
O Mental Disorders Benefit Rider O Heart Transplant Benefit Rider
O Bone Marrow Transplant Benefit Rider O Other_____

O MedComplete O MedSaver Complete
Deductible Options:
O $1,000 O $2,000 O $3,000 O $5,000
O $1,500 O $2,500 O $4,000 O $10,000
Coinsurance Options:
O PPO 80% of $10,000 Non-PPO 60% of $10,000
O PPO 60% of $5,000 Non-PPO 60% of $10,000
O PPO 60% of $10,000 Non-PPO 60% of $20,000
Optional Riders:
O Waiver of Premium Rider *(Not available for MedSaver Complete)*
O Dr. Office Co-Pay Rider (Only available with deductibles of $1,000, $1,500, $2,000 and $2,500)
O Maternity Rider O Osteoporosis Benefit Rider
O Mental Disorders Benefit Rider O Heart Transplant Benefit Rider
O Bone Marrow Transplant Benefit Rider O Other_____

O MedEssential – HSA O MedSaver HSA
Deductible Options:
Individual O $1,200(70% plan only) O $2,000
O $2,700 O $3,500 O $5,000 (100% Plan Only)
Family O $2,400(70% plan only) O $4,000
O $5,400 O $7,000 O $10,000 (100% Plan Only)
Coinsurance Options:
O PPO 100% Non-PPO 80%
O PPO 70% Non-PPO 60%
Calendar Year Maximum Benefit Per Insured for Outpatient Treatment
O $5,000 O $10,000 O $15,000 O $25,000
(The $5,000 maximum is not available on deductibles of $3,500, $5,000, $7,000 or $10,000)
Calendar Year Maximum Per Insured for Outpatient Prescription Drugs
O $2,000
O Calendar Year Maximum Per Insured for Outpatient Treatment
Optional Riders:
O Waiver of Premium Rider*(Not available for MedSaver)*
O Osteoporosis Benefit Rider O Mental Disorders Benefit Rider
O Heart Transplant Benefit Rider O Bone Marrow Transplant Benefit Rider
O Radiation/Chemotherapy Rider O Other_____

O MedEssential
Deductible Options:
O $1,200 O $1,700 O $2,500
Coinsurance Options:
O PPO 70% Non-PPO 60%
Calendar Year Maximum Benefit Per Insured/Calendar Year Maximum Per Insured for Outpatient Treatment Options:
O $50,000/$2,500 O $100,000/$2,500
O $100,000/$5,000 O $250,000/$5,000
O $250,000/$10,000
Calendar Year Maximum Per Insured for Outpatient Prescription Drugs
O $2,000
O Calendar Year Maximum Per Insured for Outpatient Treatment
Optional Riders:
O Waiver of Premium Rider O Dr. Office Co-Pay Rider
O Osteoporosis Benefit Rider O Mental Disorders Benefit Rider
O Heart Transplant Benefit Rider O Radiation/Chemotherapy Rider
O Bone Marrow Transplant Benefit Rider
O Other_____

OTHER COVERAGE PLANS

Total Base Plan Premium $_____

O Asset Deductible Options: O $1,000 O $1,500 O $2,000 O $2,500 O $5,000 O $10,000
Coinsurance Options: O PPO 80% Non-PPO 60%
O Optional Outpatient Therapy and Testing Rider O $500 O $1,000
O Optional Osteoporosis Benefit Rider O Optional Mental Disorders Benefit Rider
O Optional Heart Transplant Benefit Rider O Optional Bone Marrow Transplant Benefit Rider
O Other_____ Premium $_____

O Dental Expense List applicant alphabetic indicator (A, B, C etc.) for all applicants applying for dental coverage.
Premium $_____

TOTAL PREMIUM COLLECTED $_____

BENEFICIARY DESIGNATION

Your Beneficiary: _____ Spouse's Beneficiary: _____

Current and Prior Coverage

APP

Other Coverage – Please answer the following questions

1. Does any applicant(s) currently have, or has any applicant made application for any type of health insurance? O Yes O No
   If Yes complete below.

Company Name: _____ Phone # _____ Type of Coverage _____ Date Effective _____

2. Are all applicant(s) covered under prior coverage? If No, list below those not covered: O Yes O No

   _____

3. Is the coverage you are applying for intended to replace your existing coverage? O Yes O No
   If yes, please be advised that you should not cancel your current coverage until you receive and review your Policy, if issued.
4. Has any applicant been declined, had coverage excluded, been charged extra premium, or been postponed for any kind of personal insurance within the last ten years, or in the past 18 months filed a claim for disability, or are you or any member listed receiving benefits from Social Security or Workers' Compensation? O Yes O No
   If yes, provide details _____

Medical History

1. Please list all drugs prescribed or taken in the past 12 months.

Applicant _____ RX/Med _____ Reason _____ Doctor _____

Applicant _____ RX/Med _____ Reason _____ Doctor _____

Applicant _____ RX/Med _____ Reason _____ Doctor _____

Applicant _____ RX/Med _____ Reason _____ Doctor _____

2. Has any applicant been diagnosed with, treated or taken medications for, consulted with, had symptoms of, or been advised to seek treatment within the last ten years for any disease or disorder of the:
   a) Lungs or Respiratory system including but not limited to Asthma, Allergies, Pneumonia, Chronic Bronchitis, Emphysema or Sleep Apnea? O Yes O No
   b) Heart or Circulatory system including but not limited to High Blood Pressure, Coronary Artery Disease, Heart Attack, Stroke, Heart Murmur, Congestive Heart Failure, Mitral Valve Prolapse, or Irregular Heartbeat? O Yes O No
   c) Blood or Blood forming organs including but not limited to Anemia, Hemophilia, or Blood Clots? O Yes O No
   d) Stomach, Esophagus, Intestines, Rectum, or Digestive system including by not limited to Ulcers, Colitis, Gastritis, Crohn's disease, Hernia, Hemorrhoids, or Gallbladder disease? O Yes O No
   e) Liver including but not limited to Hepatitis, or Cirrhosis? O Yes O No
   f) Kidneys or Urinary System including but not limited to Kidney Stones, Urinary Tract Infections, Cystitis, or Urinary Incontinence? O Yes O No
   g) Pancreas including but not limited to Pancreatitis, Diabetes, or Sugar/Glucose Intolerance? O Yes O No
   h) Thyroid, Pituitary, Adrenal or Endocrine glands including but not limited to Hyperthyroidism, Graves' Disease, or Goiter? O Yes O No
   i) Neuromuscular system including but not limited to Parkinson's Disease, Muscular Dystrophy, or Lou Gehrig's Disease ALS? O Yes O No
   j) Muscles, Joints, or Connective Tissues including but not limited to Rheumatism, Arthritis, Rheumatoid Arthritis, Gout, Fibromyalgia, Temporomandibular Joint disorder, (TMJ), Carpal Tunnel Syndrome, Lupus or Lyme disease? O Yes O No
   k) Back, Neck or Spine including but not limited to Sprain or Strain, Herniated or Slipped Disc, Chiropractic Adjustments or Spinal Manipulations? O Yes O No
   l) Brain or Central Nervous System including but not limited to Convulsions, Epilepsy, Seizures, Recurrent Headaches, Migraine(s), Dementia, Multiple Sclerosis, or Paralysis? O Yes O No
   m) Skin including but not limited to Psoriasis or Eczema? O Yes O No
   n) Eyes, Ears, Nose or Throat including but not limited to Glaucoma, Cataracts, Blindness, Tubes in Ears, Deafness or Hearing loss, Cochlear Implants, or Chronic Tonsillitis? O Yes O No
   o) **Male Applicant(s)** – Breast, Prostate, or Male Reproductive System including but not limited to an abnormal PSA test or impotence? O Yes O No
   p) **Female Applicant(s)** - Breast or Female Reproductive System including but not limited to Endometriosis, Pelvic Pain, Menstruation Disorder, Abnormal Pap Test, Cyst or Fibroid Tumors? O Yes O No
   q) **Female Applicant(s)** Has any applicant ever had a Cesarean Section, miscarriage, abortion, or premature delivery? O Yes O No

3. Is any applicant listed currently pregnant, or expecting a child with anyone, whether or not listed on this application, or in the process of adoption? O Yes O No
4. **Has any Applicant** within the last ten years:
   a. received consultation, testing, or counseling for infertility, impotence, in-vitro fertilization, artificial insemination, or surrogacy? O Yes O No
   b. been treated for Sexually Transmitted Disease, hormone imbalance or oral contraceptive reaction of any kind? O Yes O No
   c. tested positive for the presence of the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? O Yes O No
   d. had or is any applicant considering any cosmetic or reconstructive surgery, or has any applicant ever had or been diagnosed or treated for a congenital birth defect or bodily deformity, or had or considering an organ transplant? O Yes O No
   e. had or does any applicant have a monitoring device, implants, amputation(s), prosthetic, or internal fixations (i.e. pins, plates, screws, shunt, pacemaker), or been advised to use a walking aid, wheelchair, or any other device or equipment? O Yes O No
   f. had Leukemia, Hodgkin's Disease, Lymphoma or any other form of Cancer? O Yes O No
   g. had a tumor, cyst or any form of growth? O Yes O No
   h. had mental, emotional or nervous disease or disorder including but not limited to Depression, Anxiety, Bulimia, Anorexia, Bipolar Disorder, Mental Retardation, Learning/Behavior Disorder, or Attention Deficit Disorder? O Yes O No
   i. been advised or treated for alcohol or drug abuse, used illegal drugs, been a member of any alcohol or drug support group, or been given counseling or directive to seek treatment for use or abuse of alcohol or drugs? O Yes O No
5. In the past five years, has any applicant gone to any health care professional for diagnosis, advice, treatment, checkup or consultation, been recommended treatment, or been confined to a hospital, clinic, or other medical facility for any condition, disease or disorder not listed above? O Yes O No
6. Has any applicant been cited for a DWI or DUI or had their driver's license suspended or revoked in the past 5 years, or currently on probation or been convicted of a felony in the past 10 years? O Yes O No
7. Are all applicants U.S. Citizen(s) or do all applicants have Permanent Residence status (Green Card)? O Yes O No
8. Do any applicants participate in any hazardous avocation or sport including but not limited to vehicle racing, skydiving, pilot or student pilot, scuba diving, rock or mountain climbing, or rodeo? O Yes O No
9. Has any applicant traveled outside the U.S. for more than 30 days in past two years, or does any applicant plan to travel outside the U.S. for more than 30 days in the next two years? O Yes O No
10. Has any person proposed for coverage had an immediate family member diagnosed with heart disease, heart attack, stroke, kidney disorder, diabetes, cancer, leukemia, or Hodgkin's Disease? (An immediate family member is a father, mother, brother or sister.) O Yes O No

Please provide details to any "Yes" answers to questions 1 through 10 above in the section below.

Applicant: _____ Question _____ Condition _____
Treatment Dates _____ Doctor/Hospital Name/Address/Phone _____

Applicant: _____ Question _____ Condition _____
Treatment Dates _____ Doctor/Hospital Name/Address/Phone _____

Applicant: _____ Question _____ Condition _____
Treatment Dates _____ Doctor/Hospital Name/Address/Phone _____

Applicant: _____ Question _____ Condition _____
Treatment Dates _____ Doctor/Hospital Name/Address/Phone _____

Applicant: _____ Question _____ Condition _____
Treatment Dates _____ Doctor/Hospital Name/Address/Phone _____

Home Office Corrections:

Notices

APP

Fraud Notices:

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

Georgia Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime.

Ohio Residents: 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.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For all States other than those mentioned above: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Consumer Report Notice:

This is to inform you as part of our procedure for processing your application an investigative report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

Release of Information Notice:

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may however, make a brief report thereof to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

The Company or its reinsurer may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted.

Applicant's Acknowledgments And Authorizations APP

By signing below I understand, certify and agree that:

- The health insurance coverage that I am applying for is not designated nor intended to be a health insurance plan that is employer provided.
- I am applying as an individual and the company will individually evaluate and underwrite my application.
- No part of the premiums or benefits are paid by my employer, nor will I be reimbursed through wage adjustment or otherwise for any portion of the premium to be charged.
- The insurance coverage I am applying for shall not be treated by an employer as a part of a plan or program for the purpose of section 162, 106, or section 125 of the Internal Revenue Code.
- Freedom Life Insurance Company of America will confirm the information provided on this application for insurance with a verification telephone call. This verification call is a routine process for those applying for coverage with Freedom Life Insurance Company of America and that this telephone call will be recorded. I also understand that my application will not be considered if verification is not completed.
  I (or my spouse, if applicable) may be contacted at the telephone numbers listed on the first page. If I cannot be contacted, I will call Freedom Life Insurance Company of America at 1-800-387-9027.
- I hereby apply to Freedom Life Insurance Company of America for insurance coverage to be issued in reliance upon the answers made to the best of my knowledge and belief and agree that the answers are full, true and complete in their entirety. I agree that the information and answers given shall form the basis for and be a part of any insurance under which coverage is issued. The coverage shall not be effective until a Policy has been actually issued and delivered to the Insured, with first premium paid while the health of all persons named in this Application remains as stated therein.
- The agent is not an officer of the Company and cannot change, alter or amend the application, the Policy or any information requirement of the Company. I further understand that the agent has no authority to make any representations about the conditions under which the Company will issue a Policy or make coverage under the Policy effective.
- If coverage is offered that it shall be subject to the timely payment by me and receipt by the Company of the Initial Premium amount and Policy administration fees. Should payment of such Initial Premium and fees not be timely made and received or returned for insufficiency of funds or in any other way insufficient or not honored, I understand, acknowledge and agree that the corresponding offer of coverage is withdrawn, void and of no effect.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information to make determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I hereby acknowledge receipt of the Medical Information Bureau (MIB), the Notice of Information Practices and Privacy Policy, and the Fair Credit Reporting Act (FCRA) notice.
- My/our answers to the questions and the information provided in application are complete, accurate and true to the best of my/our knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to Policy provisions, unless otherwise provided.

Attention Applicant: I hereby certify and affirm that my/our responses to the questions contained on this application are complete, accurate and true to the best of my/our knowledge and belief, I understand and acknowledge that any fraudulent statement of material misrepresentation on the application and/or amendments may result in claim denial or contract rescission. I further understand that losses due to Pre-existing Conditions, diseases or bodily injuries occurring prior to the effective date of coverage are not covered, subject to the Policy provisions, unless otherwise provided. If your electronic signature cannot be provided, your verbal electronic signature will be obtained during a recorded telephone interview before coverage will be considered.

Dated at _____
(City) (State) (Month) (Day) (Year)

✖ _____ ✖ _____
Signature of Applicant Signature of Spouse, if Applicable

I certify that I have truly and accurately recorded on the application form the information supplied by the applicant and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance.

I certify that I have reviewed this application, and that it has been completed in full for submission to Freedom Life Insurance Company of America.

Agent's Signature _____ Agent # _____ Date: _____

FREEDOM LIFE™
INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102

This notice is provided to you under the requirements of federal legislation entitled the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This is a periodic notice that you will continue to receive while you are insured with our Company. This notice **does not** affect your coverage in any way. **No action is required of you.**

Effective date of this notice: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY

In order to provide you with benefits, Freedom Life Insurance Company of America will receive personal information about your health, from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits. We disclose members' information to health care providers to assist them to provide you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members information as required by law or as permitted by Freedom Life Insurance Company of America policies.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

WHO MUST ABIDE BY THIS NOTICE

- Freedom Life Insurance Company of America.
- All employees, staff, and other personnel whose work is under the direct control of Freedom Life Insurance Company of America.

The people and organizations to which this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION.

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. This means that our employees, staff, and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to help you make decisions about your care. We will also disclose your information to others to provide you with medical treatment or services.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, an employee in our claim processing department may use your health information to pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the insured and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, accreditation services, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by the state insurance department. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may

disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes or workers' compensation and work site safety laws (OSHA, for instance).

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Information to Members. We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options, alternative setting for care, or other health-related services that may be eligible under your plan.

12. Health Benefits Information. If your enrollment in your health plan is sponsored by your employer, your health information may be disclosed to your employer, as necessary for the administration of your employer's health benefit program for employees. Employers may receive this information only for purpose of administering their employee group health plans, and must have special rules to prevent the misuse of your information for other purposes.

YOUR RIGHTS

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Inspect and Receive a Copy of Health Information. You have the right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the name of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. We cannot include disclosures made before April 14, 2003. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Secretary of the U.S. Department of Health and Human Services, at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Room 509F HHH Bldg., Washington, D.C. 20201. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all subscribers within 60 days of the effective date.

WHOM TO CONTACT.

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Office
3100 Burnett Plaza
801 Cherry Street, Unit 33
Fort Worth, Texas 76102
1-800-387-9027

This notice is also available by e-mail. Contact the person named above, or send an e-mail to: flica@insurance-privacy.com

Authorization to Use and Disclose Protected Health Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has records or knowledge of me, or any member of my family who is to be insured, to give (disclose) to Freedom Life Insurance Company of America or its reinsurer any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give all such records or knowledge to any agency employed by Freedom Life Insurance Company of America to collect and transmit such information. I authorize Freedom Life Insurance Company of America to use such information in determinations regarding enrollment, underwriting, eligibility of benefits, or any other healthcare operations related to the consumer as a prospective insured or as an insured with Freedom Life Insurance Company of America. A photographic or electronic copy of this authorization shall be as valid as the original. This authorization shall be valid for two years from the date signed. I have received a copy of the Freedom Life Insurance Company of America Notice of Privacy Practices.

Print Applicant's Name	Applicant's Signature	Date
Print Spouse's Name	Spouse's Signature	Date

Notice to Consumer

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Company Privacy Official, 3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas, 76102. The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed, if we have already taken action in reliance on the authorization. Since this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services EXCEPT in the following circumstances:

- If the only purpose for providing you with a service is to obtain health information to disclose to someone else, then you must authorize that disclosure in order to receive the service.
- If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

You do not have to sign this authorization to receive payment, to enroll in the plan, or to be eligible for benefits, except:

- If this authorization is sought for the purpose of determining your eligibility for benefits or is necessary for any other healthcare operations, then you must authorize Freedom Life Insurance Company of America to obtain the necessary information or the benefits, enrollment, or provision of service through other healthcare operations may be denied.
- If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize Freedom Life Insurance Company of America to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

(Herein referred to as the "Company")

3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas 76102, 1-800-387-9027

Thank you for considering us for your health insurance protection. We would like to provide you with some additional information regarding the processing of your application. We request that as part of considering your application, you complete a telephone interview so that we may confirm the information provided on your application and gather any additional health information as needed. The interview generally takes from 15 to 20 minutes to complete, and may go longer based on the number of people listed on the application and their overall medical history. Please be advised that in signing your application, you agreed and understood that this call will be recorded, and your application can only be considered once the verification call is completed. If we are unable to contact you within 15 days of completing your application, please call us at 1-800-387-9027. So that we can complete this interview as quickly as possible, we ask that you have available the following information. Please use the space below to record the information needed.

Healthcare Providers: Please have the name, address, and phone # of any provider(s), for each person listed on the application.

_____

_____

_____

Medications: Please provide the name of any medication(s), dosage and frequency, reason taken, and dates taken.

_____

_____

_____

Medical History: Please be ready to provide details for any medical condition(s) for which any applicant has been diagnosed, treated, or taken medication for, including dates of treatment and name of treating healthcare provider.

_____

_____

_____

Notice: This is to inform you as a part of our procedures for processing your application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation. Information regarding your insurability will be treated as confidential. The Company or its reinsurers may however, make a brief report thereof to the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number is (866) 692-6901 (TTY (866) 346-3642 for hearing impaired). The Company or its reinsurer may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted.

Notice: You are not required to disclose your Social Security Number, but we request it to aid in our administrative procedures.

INITIAL RECEIPT

The initial payment of $_____ has been conditionally accepted by the Company. The coverage being applied for shall not be effective until a Certificate/Policy has actually been issued and delivered to the Insured, with the first premium paid while the health of all persons name in the application remains as stated therein. This receipt shall be void if given for a check, draft or payment, which is not honored. All checks or payments must be made payable to the Company: DO NOT make check or payment payable to the agent, or leave the payee blank.

Agent acknowledges receipt of payment and delivery of this receipt.

Agent Signature_____ Agent Number_____

(Leave this form with Applicant)

CR-06/06-FLIC

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas 76102

Authorization to Charge Credit Card for Initial Payment Only

I hereby request, authorize, and instruct Freedom Life Insurance Company of America to charge my initial payment to my Credit Card account as listed below:

Credit Card Type: ❑ VISA ❑ Master Card ❑ American Express ❑ Discover

Account # _____ Expiration Date _____

Name on Card (First) _____ (Middle) _____ (Last) _____

Billing Address _____

Signature of Cardholder _____

Our preferred method for renewal payments is bank draft, please complete the information below and attach a voided check

Authorization to Honor Checks Drawn by Freedom Life Insurance Company of America

I hereby request, authorize, and instruct Freedom Life Insurance Company of America (Company) to initiate charges (debits) on my bank and checking account listed below, provided there are sufficient collected funds in the said account. I understand that payments will be debited from the account as designated below, and I requested (select one):

- ❑ to begin withdrawals (debits) on the date my coverage is made effective, if approved.
- ❑ to begin withdrawal to coincide with my requested effective date for the _____ (1-28th) day of the month, if approved.

The Company may revoke payment under this method if any payment is dishonored. I understand and affirm that the Company has my authorization to draft my bank and checking account shall until I notify, and the Company receives, my request for an alternative payment mode in order to keep the coverage paid current. I also understand that the coverage applied for shall be subject to the terms, provisions and conditions of the Policy, and that the coverage shall not be effective until a Policy has been actually issued by the home office of the Company, and delivered to the Primary Applicant, with the first premium paid while the health of all persons named remains as state in the application.

Please attached below a voided check.

Authorized Account Holder: _____

Printed Name of Account Holder if different from applicant.

Signature of Account Holder: _____ Date _____

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

(Hereinafter referred to as the "Company")
3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102
1-800-387-9027

Initial RECEIPT Date _____

Received of _____

Address _____

The initial payment of $_____ has been conditionally accepted by the Company.

Being the initial _____ months payment on the application for a policy to be issued by the Company, in Fort Worth, Texas. I understand that the insurance applied for shall be subject to the provisions and conditions of the policy, and that the coverage shall not be effective until a policy has been actually issued and delivered to the Insured, with the first premium paid while the health of all persons named in the application remains as stated in the application.

This receipt shall be void if given for a check or draft, which is not honored on presentation. All checks must be made payable to the Company: DO NOT make check payable to the agent or leave the payee blank.

Agent Signature _____ Agent Number _____
If the application is not acknowledged or policy received within forty (40) days, notify the Company immediately at 1-800-387-9027.

TELEPHONE CONTACT AUTHORIZATION AND AGREEMENT: To expedite the processing of my application for insurance, I authorize the Company to contact me by telephone to verify information recorded on my application for insurance. I understand and agree that the insurance coverage may be issued to me based solely and entirely upon the information provided in the application for insurance and by any telephone verifications. Should I be contacted by telephone, I authorize and consent to the recording of the conversation and I agree that such recording can be made a part of my application for insurance. I further represent that I will fully and truthfully answer all questions or inquiries made of me during any telephone verification.

Please allow two weeks processing time. If you have not been contacted by the Home Office after that time, please call our toll free number 1-800-387-9027. If we are unable to take your call, please leave your name, phone number with area code, state of residence, application number if known, and best time to call back.

NOTICE: This is to inform you as part of our procedure for processing your application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may however, make a brief report thereof to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon Receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

The Company or its reinsurer may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim of benefits may be submitted.

NOTICE: You are not required to disclose your Social Security Number, but we request it only to aid in our administrative procedures.

(Leave with Applicant)