Vault Shield Plus

SEX ☐F ☐M	PROPOSED INSURED FIRST NAME:	MIDDLE INITIAL:	LAST NAME:
PROPOSED INSURED'S RESIDENCE ADDRESS	CITY	STATE	ZIP
PROPOSED INSURED'S DATE OF BIRTH (Mo/Day/Year)	AGE	SOCIAL SECURITY OR TAX ID (**LAST 4 DIGITS**)	
PHONE NUMBER – LANDLINE PHONE	PHONE NUMBER – MOBILE PHONE		
EMAIL ADDRESS:			
MAILING ADDRESS FOR COMPANY CORRESPONDENCE (only if it is different from residence address)	CITY	STATE	ZIP
PROPOSED INSURED'S EMPLOYER NAME:		EMPLOYER PHONE NUMBER:	
PROPOSED INSURED'S EMPLOYER ADDRESS:	CITY	STATE	ZIP

Please provide any other Vault Policy Number Please indicate where the Proposed Insured would like to receive annual notices, policy contract, or relate documents.
☐Residence ☐Mailing Address ☐Business

Please indicate where the Proposed Insured would like to be contacted by an Agent. ☐Residence ☐Business

Will this policy replace any existing policies for the Proposed Insured and/or Spouse*? ☐YES ☒NO Vault Policy No:
(If "Yes" please complete Replacement Form)

Other: Type of Policy: Company Name: Policy No.

*** In this application, the term "Spouse" refers to either a Spouse or Domestic Partner.**

Check the most convenient phone number and time to call:

An Authorized Interviewer may call to obtain additional information required to complete this application.

☐Mobile ☐Landline ☐Employer ☒Other:

☐6:30 a.m. - 8:00 a.m. ☐8:00 a.m. - 12:00 p.m. ☐12:00 p.m. - 3:00 p.m. ☐3:00 p.m. - 6:00 p.m. ☐After 6:00 p.m.

BENEFICIARY INFORMATION			
BENEFICIARY'S FULL NAME:		BENEFICIARY PHONE NUMBER	
BENEFICIARY ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO PROPOSED INSURED	AGE	SOCIAL SECURITY NUMBER (**LAST 4 DIGITS**)	DATE OF BIRTH (Mo/Day/Year)

QUALIFICATION QUESTIONS (Required for Shield Plus Coverage)

I represent that the answers to the below questions are accurate and complete to the best of my knowledge AND BELIEF.

Question	Proposed Injured	Spouse*
1. Is the Proposed Insured and/or Spouse* unemployed or working less than 20 hours per week?	☐YES ☒NO	☐YES ☐NO
2. Within the past twelve (12) months has the Proposed Insured and/or Spouse* been advised of the need for hip, back, herniated disc, spine, shoulder, knee, or joint surgery?		☐YES ☐NO
4. Within the past 5 years, has the Proposed Insured and/or Spouse* received medical diagnosis or treatment from a member of the medical profession or taken any prescription medication for:		
a. Heart attack, angina, coronary artery disease with angioplasty, stent placement, heart valve disease or defect, or a disease or defect of the aorta?		☐YES ☐NO
b. Stroke, transient ischemic attack, multiple sclerosis, or insulin dependent diabetes?		☐YES ☐NO
c. Cancer (except basal cell carcinoma or squamous cell carcinoma), leukemia, or brain tumor?		☐YES ☐NO
d. Kidney failure or organ transplant?		☐YES ☐NO
e. Bipolar disorder, schizophrenia, psychosis, alcoholism or drug addiction?		☐YES ☐NO
5. Has the Proposed Insured and/or Spouse* been diagnosed by a member of the medical profession with high blood pressure requiring 4 or more medications?		☐YES ☐NO
6. Has the Proposed Insured and/or Spouse* been diagnosed by a member of the medical profession with non-insulin diabetes under age 40?		☐YES ☐NO
7. Is the Proposed Insured and/or Spouse* currently pregnant? (not applicable if male)		☐YES ☐NO
If any of the above questions 1-7 are answered "Yes", the Proposed Insured and/or Spouse* is not eligible for coverage		

PROPOSED INSURED'S INFORMATION

HEIGHT (ft. in.)	WEIGHT (lbs)	INSURED'S DRIVER'S LICENSE:	STATE
1.Within the past 12 months, has the Proposed Insured used tobacco products? ☐YES ☐NO			
2. Proposed Insured's Occupation:			
3. If self-employed, what is your net annual business income (business income minus business expenses)? $			
4. If not self-employed, what are your gross annual earnings from your primary occupation? $			

SPOUSE* INFORMATION

SEX: ☐F ☐M	SPOUSE'S* FIRST NAME	MIDDLE INITIAL	LAST NAME
SOCIAL SECURITY NUMBER (**LAST 4 DIGITS**):		SPOUSE'S* DATE OF BIRTH (Mo/Day/Year):	
HEIGHT (ft. in.)	WEIGHT (lbs)	INSURED'S DRIVER'S LICENSE	STATE
1.Within the past 12 months, has the Spouse* Insured used tobacco products? ☐YES ☐NO			
2. Spouse's* Occupation:			
3. If self-employed, what is the net annual business income (business income minus business expenses)? $			
4. If not self-employed, what are the Spouse's* gross annual earnings from their primary occupation? $			
5. Please provide any other Vault Health Policy Number			

SPOUSE'S* EMPLOYER NAME	EMPLOYER PHONE NUMBER		
SPOUSE'S* EMPLOYER ADDRESS	CITY	STATE	ZIP

PLAN SECTION: Shield Plus and Sickness Coverage		
Proposed Insured Monthly Benefit Amount:	☐$500 ☐$800 ☐$1 ,000 ☐$1 ,200 ☐$1 ,500	
Spouse* Monthly Benefit Amount	☐$500 ☐$800 ☐$1 ,000 ☐$1 ,200 ☐$1 ,500	
QUESTION	Proposed Insured	Spouse*
1. Within the past 12 months, has the Proposed Insured and/or Spouse* missed 5 consecutive days or more of work as a result of an accidental injury or sickness? (If "Yes", provide details below.)	☐YES ☐NO	☐YES ☐NO
2. Is the Proposed Insured and/or Spouse* currently applying for, or does the Proposed Insured and/or Spouse* currently have other disability coverage in force, including but not limited to, individual disability coverage; group disability coverage; sick pay lasting longer than 90 days; and/or Salary Continuation benefits through the Proposed Insured's or Spouse's* employer? (If "Yes", provide company name, benefit period, and monthly benefit below.)	☐YES ☐NO	☐YES ☐NO

Physician(s) Name: Address (Street, City, State, Zip) & Phone	
Proposed insured	spouse*

DECLARATIONS — This section must be read, signed, and dated by Proposed Insured.

PLEASE READ CAREFULLY - It is very important that you review the application carefully. Misstatements or omissions whether made in writing or orally for any portion(s) of the application that are completed through use of telephone or other electronic means, could cause an otherwise valid claim to be denied if the misstatement or omission was made with actual intent to deceive or it materially affected the acceptance of your application or the risk assumed by Vault Admin Services. Please check the application carefully and advise your agent/producer if any information is not correct or not complete or if any medical history has not been included. I understand that any insurance applied for will not take effect unless and until Vault Admin Services approves my application, the contract is issued, and the required premium is received by Vault Admin Services In applying for this coverage, I represent and affirm the following:

1. The information which I have given as recorded on this Application including income verification is true and complete to the best of my knowledge and belief.
2. I received the Outline of Coverage and Notice of Information Practices and if applicable, the Medical Information Bureau (MIS) Disclosure Statement.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION - I authorize Vault Admin Services or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager; Health Plan; Government Agency; MIB, Inc. (MIB); Consumer Reporting Agency; Vault Admin Services' own records; and I authorize any of the foregoing parties that have any records of my protected health information to give to Vault Admin Services or its reinsurers, any such information. Vault Admin Services will acquire through a written form or through a personal phone interview or another means from the above any needed information (excluding HIV/AIDS/ARC) on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Vault Admin Services or its reinsurers to disclose all such information to any doctor, the MIB or any other insurance company in order to evaluate a claim or an application for insurance. I authorize Vault Admin Services, or its reinsurers to make a brief report of my protected health information to MIB Inc. Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. I understand this consent may be revoked in writing at any time with the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days from the date of signing.

The nature of this authorization release request is to allow Vault Admin Services Underwriters to seek and obtain medical information from those entities listed in the previous paragraph. The medical information obtained is used in determining your insurability. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company.

You may revoke this authorization anytime by writing Vault Admin Services; however, such revocation may affect coverage. Failure to sign this authorization may impair the ability of Vault Admin Services to evaluate or process this application and may be a basis for denying this application.

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

I authorize Vault Admin Services to show my name, firm name, occupation, city, and years with Vault Admin Services as a policyholder to prospective Proposed Insureds.

☐ YES ☐ NO

Signature:		
Date:	City (where signed):	State (where signed):

I, the authorized agent/producer, have on the Date of Application recorded the information as given to me. I have delivered the Notice of Information Practices and Outline of Coverage. I have no knowledge of any unfavorable medical history not recorded on this Application. I certify that I have inspected this application for completeness and according to our field underwriting guidelines it may be submitted to the Home Office for further underwriting review.

Signatures

Licensed Agent/Producer:	Agent's/producers Signature:	Code#:
Sale Manager:	Managers Signature:	Code#:
Date:		

Primary Agent/Producer contact information
Agent's/Producer's phone:
Agent's/Producer's e-mail address:
Agent's/Producer's cell phone: