Junior Estate Builder

They grow up fast.
Protect them while you can.

HUMANA
Guidance when you need it most

Humana Financial Protection Products

GCA06TIHH 10/09 FL

Junior Estate Builder

Care for the children you love by insuring their future.

Give the priceless gift of protection. Humana's **Junior Estate Builder** life insurance protects your child or grandchild, now and in the future, by establishing financial security that lasts a lifetime.

It works like this:

- You'll start out with the protection of term life insurance with low premiums
- At age 25, the policy automatically converts to a whole life policy
- The whole life policy builds cash value with the option to increase coverage

The plan provides:

✔ **Affordability** – Low annual premium.*

✔ **No-risk, no hassles** – No medical exam or interview.
Plus you can return the policy within 30 days for a full refund.

✔ **Flexibility** – Additional coverage can be purchased at ages 25, 28, and 31 without evidence of insurability.
From a $20,000 policy you can increase up to a total of $80,000 of whole life coverage.

✔ **An investment in their future** – Policy generates monetary values that may provide cash in the future.**

You choose the plan that's right for you:

Plan Option	Coverage Amount	Locked-in Annual Premium
Plan One	$15,000 coverage	Only $35 / year
Plan Two – *BEST VALUE!*	**$20,000 coverage**	**Only $45 / year**

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Junior Estate Builder is Kanawha Insurance Company policy Form 20305 1/88. Limitations and exclusions apply. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies. Available for ages 0 - 24 years (nearest age).

*At age 25 there is a one-time premium increase upon conversion from term to whole life.

** Monetary value accumulations begin after the policy converts to whole life at age 25.

Application for Junior Estate Builder

Check the plan applying for:

❑ **Plan 20305** — Face Amount $15,000
Annual Premium $35

❑ **Plan 20306** — Face Amount $20,000
Annual Premium $45

Kanawha Insurance Company
210 South White Street
Post Office Box 7777
Lancaster, South Carolina 29721-7777

Producer Number _____

Proposed Insured(s)*	Home Office Use Policy Number	State of Residence	Sex M/F	Age	Date of Birth	State of Birth	Height	Weight
①								
②								
③								

*Proposed Insured(s) referred to as you or your.

	① Yes	① No	② Yes	② No	③ Yes	③ No
1. Within the past 7 years has Proposed Insured:						
a. Been diagnosed or treated for heart disease or any abnormalities of the heart, diabetes, kidney disease, anemia, immunodeficiency disease or disorder by a member of the medical profession?	❑	❑	❑	❑	❑	❑
b. Had any health, mental or physical impairment or been excused from any physical activities at school because of medical reasons?	❑	❑	❑	❑	❑	❑
2. Within the past 3 years has Proposed Insured been confined in a hospital?	❑	❑	❑	❑	❑	❑
3. Is Automatic Premium Loan desired?	❑	❑	❑	❑	❑	❑
4. Will the policy applied for replace or change any policy in force with any company?	❑	❑	❑	❑	❑	❑

Give company name, policy number, date of issue, and amount. Complete replacement form.

Give details of "Yes" answers to questions 1 and 2. Include names and addresses of physicians, medical practitioners, hospitals, and clinics.

Proposed Insured(s)	Date, Reason, Medications, Physicians, Medical Practitioners, Hospitals, and Clinics

Beneficiary	Relationship

Please complete front and back of this application.

The undersigned applicant and producer agree that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any false statements or misrepresentations in the application may result in the loss of coverage as stated in the Incontestability Provision of the policy. If your answers on this application are incorrect or untrue, Kanawha Insurance Company may have the right to deny benefits or to rescind your policy.

Authorization: I authorize Kanawha and its reinsurers to obtain information as to the diagnosis or treatment of my or my child's physical and/or mental condition and any other information needed to determine eligibility for insurance. Upon presentation of this authorization, or a photocopy of it, which is valid for 26 months from the date shown below, Kanawha or its reinsurers may obtain information or records thereof from any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, employer, consumer reporting agency or the Medical Information Bureau, that has any records of me or my child for whom insurance application is made, or my health or my child's health, to give to Kanawha or its reinsurers any such information and to testify to such information, all to the extent permitted by law. I realize that I, or a representative on my behalf, have the right to receive a copy of this authorization.

Caution: 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.

I acknowledge that I have received a copy of the Notice to the Proposed Insured and the Medical Information Bureau Disclosure Notice which was attached to this application.

Dated at _____ (City/State) Date _____

X _____ (Signature of Owner) _____ (Relationship to Proposed Insured) _____ (Social Security Number of Owner)

X _____ (Printed Name of Owner)

Address _____ County _____

City_____ State _____ Zip _____ Within City Limits ❑ Yes ❑ No

X _____ (Signature(s) of any Proposed Insured(s) if age 15 or over) X _____ (Signature of Licensed Resident Producer)

Producer's Certification

To the best of my knowledge, replacement is ❑ is not ❑ involved. I hereby certify that I have truly and accurately recorded on the application the information supplied by the applicant.

_____ (Signature of Licensed Resident Producer) _____ (Printed Name of Licensed Resident Producer) _____ (Producer's License # or Code)

All premium checks ***must*** be made payable to **Kanawha Insurance Company. *Do not*** make check payable to the producer or leave the payee

Billing Instructions:
- ❑ Bill all policies to Owner/Applicant
- ❑ Bill each policy separately as follows:

Proposed Insured ① _____

Proposed Insured ② _____

Proposed Insured ③ _____

KANAWHA
INSURANCE COMPANY

210 South White Street, Lancaster, SC 29720
Mail: Post Office Box 7777, Lancaster, SC 29721-7777

Secondary Addressee Request

This form is being provided in accordance with Florida law 627.4555, F.S. which provides for the naming of a Secondary Addressee to receive billing notices.

Each insured is required to make an election in writing annually.

☐ I understand that I have the right to designate at least one person other than myself to receive Notice of Lapse on my life insurance policy for nonpayment of premium. I understand that the policy will be canceled for nonpayment of premium, unless, after expiration of the 31 day Grace Period and at least 21 days prior to the effective date of such cancellation, Kanawha has mailed a notification of possible lapse in coverage to me and to my specified secondary addressee, as listed below.

Name: _____
Address: _____
_____
_____
_____

☐ I elect not to designate any person to receive Notice of Lapse.

_____ _____/_____
Policy/Application # Signature, Owner Date