You can relax, knowing your final wishes will be respected.
Memorial Fund

Ensure financial peace of mind for you and your family.

You may have already planned ahead for funeral expenses. But there are so many costs your family could face, including medical bills, legal fees, taxes, and other expenses. Humana’s Memorial Fund is whole life insurance that pays cash to your designee to take care of your final expenses and more.

The plan lets you relax knowing that:

✔ Your final arrangements can be carried out
✔ You’ll avoid burdening your family with unexpected costs
✔ You’re taking the future into your hands today

The Memorial Fund is whole life insurance that has guaranteed cash values. As the policy matures, cash value in the policy grows.

Memorial Fund Benefit Features

<table>
<thead>
<tr>
<th>Individual coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy benefits from $1,000 to $25,000 in $1,000 increments.</td>
</tr>
</tbody>
</table>

Two Payment Methods

| Premiums are payable for the life of the policy or until death. |
| Pay premiums for 10 years (without lapse.) Coverage continues with no additional premiums required. |

Memorial Graded Benefit Features

This benefit may be available to individuals who do not qualify for the Memorial Fund.

<table>
<thead>
<tr>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
<th>Year Four and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% of face value</td>
<td>50% of face value</td>
<td>75% of face value</td>
<td>100% of face value</td>
</tr>
</tbody>
</table>

Memorial Fund is Kanawha Insurance Company policy Form 00800 1/88 and graded benefit policy Form 00200 3/90. Limitations and exclusions apply. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies.
Application for Memorial Fund Life Insurance
Kanawha Insurance Company

<table>
<thead>
<tr>
<th>Proposed Insured (Print First Name, MI, Last Name)</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth (MM/DD/YYYY)</td>
<td>Social Security Number</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address (Street or R.R.)</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Telephone Number</td>
<td></td>
</tr>
<tr>
<td>(</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Owner (Print First Name, MI, Last Name, if not Proposed Insured)</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Address (Street or R.R.)</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payor (Print First Name, MI, Last Name, if not Proposed Insured)</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Address (Street or R.R.)</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Primary Beneficiaries' Name, SSN and Percentage: ________________________________
Contingent Beneficiaries' Name, SSN and Percentage: ________________________________

1662 FL

210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-207-0158
Kanawha Insurance Company is a member of the Humana family of companies.
**Section A:** If any question in this section is answered "Yes", the Proposed Insured is not eligible for any coverage.

1. Have you ever tested positive to exposure to the HIV infection or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or other sickness or condition derived from the HIV infection? 
   - Yes ☐ No ☐

2. Have you ever been diagnosed or treated by a member of the medical profession as having a terminal illness? 
   - Yes ☐ No ☐

3. Are you currently:
   (a) Receiving hospice or home health care? 
   - Yes ☐ No ☐
   (b) Bedridden, confined to a hospital, nursing home, or other facility, or has confinement been recommended by a member of the medical profession? 
   - Yes ☐ No ☐

4. Have you ever been diagnosed or treated by a member of the medical profession as having Alzheimer’s disease or dementia? 
   - Yes ☐ No ☐

5. In the past 12 months have you been diagnosed or treated by a member of the medical profession for internal cancer? 
   - Yes ☐ No ☐

**Section B:** If any question in this section is answered "Yes", the Proposed Insured is eligible for the Graded Death Benefit Product. If all questions in this section are answered "No", the Proposed Insured is eligible for the Immediate Death Benefit Product.

6. Have you been diagnosed or treated by a member of the medical profession as having:
   (a) Diabetes before age 30, or suffered complications from diabetes such as neuropathy, retinopathy, kidney or vascular problems? 
   - Yes ☐ No ☐
   (b) Emphysema, chronic obstructive pulmonary disease or a lung disorder requiring oxygen? 
   - Yes ☐ No ☐
   (c) Heart attack, coronary artery disease diagnosed before age 60? 
   - Yes ☐ No ☐
   (d) Heart valve disease requiring surgery? 
   - Yes ☐ No ☐
   (e) Stroke, aneurysm or cardiomyopathy? 
   - Yes ☐ No ☐
   (f) Kidney disease, liver disease or hepatitis C? 
   - Yes ☐ No ☐
   (g) Multiple sclerosis or Parkinson’s disease? 
   - Yes ☐ No ☐

7. Within the past 5 years have you been hospitalized, diagnosed or treated by a member of the medical profession as having:
   (a) Cancer, leukemia, melanoma or any other malignancy (except basal cell skin cancer)? 
   - Yes ☐ No ☐
   (b) Mental or nervous disorder? 
   - Yes ☐ No ☐

8. Within the past 2 years, have you been treated or counseled by a member of the medical profession for alcoholism, alcohol abuse or any drug or substance abuse? 
   - Yes ☐ No ☐

**Section C:**

9. (a) Do you have any other similar coverage in force or an Application for similar insurance pending with this or any other company? 
   - Yes ☐ No ☐
   (b) Will the insurance herein applied for replace any existing insurance with this company or any other company? 
   - Yes ☐ No ☐

(If "Yes", list company, address, complete and submit replacement form.)

---

**Benefit Amount** $ [ ] [ ] [ ] (sold in $1,000 increments up to a maximum of $25,000)

**Plan Type** ☐ Immediate Death ☐ Graded Death

**Payment Period** ☐ Whole Life ☐ 10 pay Whole Life

**Payment Method** ☐ Bank Draft ☐ Credit Card ☐ Direct Bill/Check (Annual Billing Only)

(Complete Bank Draft or Credit Card Authorization. Annual fee of $12.00 applies to credit card billing.)

**Payment Mode** ☐ Monthly ☐ Semi-annual ☐ Annual

Is Automatic Premium Loan to apply? ☐ Yes ☐ No

**Total Modal Premium** $ [ ] [ ] [ ]

**Requested Effective Date** (Optional) [ ] [ ] [ ]

**Requested Effective Date** (Optional) [ ] [ ] [ ]

1662 FL  Page 2  5057293719
AUTHORIZATION FOR AUTOMATIC PAYMENT BY BANK DRAFT

Name of Depositor (Print First Name, MI, Last Name) (Attach Voided Check)

Route and Transit Number

Bank Name and Address

Authorization for automatic payment by bank draft

Debit on the _______ day of the month (1-28 only; 29, 30, 31 not available). **If no election is made, debits will be made on the day of Policy.**

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to make deductions automatically every payment period for payments of premiums from my: ☐ savings account ☐ checking account

1. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the Undersigned at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Depositor ___________________________________ Date (MM/DD/YYYY) ____/____/____

CREDIT CARD INFORMATION

Credit Card Number

Expiration Date (MM/YY)

3 or 4-digit security code found on the back of most cards:

Card Holder Information

Signature of Card Holder___________________________ Date (MM/DD/YYYY) ____/____/____

Name as it appears on the credit card statement. (If different from Proposed Insured)

Card Holder (First Name, MI, Last Name) Suffix

All charges will be made on the day of Policy.

As a convenience to me, I request and authorize **KANAWHA INSURANCE COMPANY** to charge my credit card every payment period for payment of premiums.

1. Each charge shall constitute proper notice of premium due.
2. This Authorization shall not become effective unless and until the coverage is issued.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if the credit card company does not honor the charge and the coverage shall lapse subject to nonforfeiture provisions.
5. This Authorization may be discontinued by Kanawha or by the undersigned at any time within FIVE (5) business days prior to the payment date. Upon termination of this Authorization, premiums for the Policy will be payable annually.
6. Kanawha will notify me TEN (10) days prior to any changes in payment amounts.

Signature of Card Holder______________________________ Date (MM/DD/YYYY) ____/____/____
AGREEMENTS

The statements and answers on this Application are true and complete to the best of my knowledge and belief.

It is agreed that:

(a) This Application, and any amendments hereto, shall be the basis of any insurance granted.
(b) No Insurance Producer has the authority to waive the answer to any question in this Application, to waive any of
the Company's rights or requirements or to make or alter any contract; and
(c) No insurance shall be considered in force unless and until a policy shall have been issued by the Company and said
policy manually received and accepted by the Proposed Insured and the full first premium paid thereon, all during
the lifetime of the Proposed Insured.

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.

Signed At __________________________
City

State

Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Owner

INSURANCE PRODUCER’S USE ONLY

Is this insurance being purchased to replace or change any existing insurance?................................. ○ Yes ○ No
(If "Yes", complete replacement form.)

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Printed Name of Licensed Insurance Producer

Insurance Producer License Number

Signature of Licensed Insurance Producer

Date (MM/DD/YYYY)

Insurance Producer Number % Credit

Insurance Producer Number % Credit

Insurance Producer Number % Credit
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