AMERICAN INTEGRITY
LIFE INSURANCE COMPANY

American Integrity Life Insurance Company
PO Box 22805
Hot Springs, AR 71903
Ph: (866) 524-5433 Fx: (888) 332-5144
email: admin@ailic.com web: www.ailic.com

HOSPITAL INDEMNITY INSURANCE APPLICATION

Section 1: Proposed Insured Information (Print Only)		
First Name	M. I.	Last Name
Home Address		Social Security Number
City		Primary Phone
State Zip		Email

AGE	DATE OF BIRTH	GENDER
		☐ Male ☐ Female

Section 2: Plan and Premium Information (Print Only)			
Hospital Confinement Daily Benefit:		Maximum Benefit Period per Confinement:	
Optional Outpatient Surgery Rider: ☐ Yes ☐ No			
Will this Policy replace an existing Accident and Health insurance Policy? ☐Yes ☐No (If yes, complete a replacement notice)			
Payment Mode:	Monthly ☐	Quarterly ☐	Semi-Annual ☐ Annual ☐
Payment Method:	Bank Draft ☐	Credit Card ☐	Social Security Pre-Paid Debit * ☐ Direct Bill ☐
**Note: If you choose "Social Security Pre-Paid Debit", your re-occurring draft date must be your debit card's deposit date. See page 3 for details.*			
Initial Bank Draft:	Issue Date ☐	Effective Date ☐	Re-occurring Draft Date
Policy Premium: $	Rider Premium: $	Policy Fee: $	Total Premium: $

Section 3: Agent's Certification

I hereby certify that: (1) the insurance being applied for is suitable for the Proposed Insured's insurance needs; (2) I've explained to the Proposed Insured 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 Proposed Insured; (5) the Proposed Insured's signature is that he or she has represented to be; and (6) the application was signed by the Proposed Insured in my presence.

This policy does ☐ does not ☐ replace other insurance.

Licensed Agent's Signature

Date Signed (mm/dd/yyyy)

Agent Number

Signed At

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Section 4: Health Questions

Please check "Yes" or "No" beside each question. If the answer to any question is "Yes", a policy cannot be issued.

1. In the past two years have you seen a Physician, been diagnosed, treated or taken medication for or been advised to have treatment, surgery or take medication for:
   a. Internal cancer, leukemia, melanoma, Hodgkin's disease or lymphoma? Yes ☐ No ☐
   b. Parkinson's disease, Multiple or Amyotrophic Lateral Sclerosis, Alzheimer's disease, dementia or drug or alcohol use? Yes ☐ No ☐
   c. Congestive heart failure, stroke, heart attack, heart disease, cardiomyopathy, aneurysm or peripheral vascular disease? Yes ☐ No ☐
   d. Chronic kidney disease or kidney failure, organ transplant, cirrhosis of the liver or chronic pancreatitis? Yes ☐ No ☐
   e. Complications of diabetes (such as neuropathy, eye or kidney disease) or do you take more than 50 units of insulin per day? Yes ☐ No ☐
   f. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
   g. Chronic Obstructive Pulmonary Disease (COPD), emphysema or a condition requiring the use of a CPAP, nebulizer or oxygen? Yes ☐ No ☐
   h. Osteoporosis with related fractures or any connective tissue disorder? Yes ☐ No ☐
2. In the past twelve months have you:
   a. Been confined to a nursing facility, bed or wheelchair or received home health care? Yes ☐ No ☐
   b. Been hospitalized two or more times or been advised to have surgery that is not yet completed? Yes ☐ No ☐
   c. Used a walker, transcutaneous electrical nerve stimulator (TENS) unit or quad cane? Yes ☐ No ☐
3. Do you have a pacemaker or defibrillator or have you ever had an amputation due to disease? Yes ☐ No ☐

Please list all prescribed medications and dosages:

Section 5: Agreement and Acknowledgement

I hereby apply to American Integrity Life Insurance Company for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions. To the best of my knowledge and belief, the answers are true and complete. I represent that I am not currently covered under the State Medicaid program. I understand and agree that any falsity of any answer or statement in this application may result in benefits being denied or rescission of the policy. I understand and agree that the policy applied for will not take effect until issued by the Company and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

I have received the Outline of Coverage.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Dated at: _____ on: _____ 20 _____
City ,State and Zip Month and Day

Signature of Applicant: _____

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Section 6: Automatic Payment Authorization

As a convenience to me, I hereby request and authorize You to pay and charge to my bank account or credit card checks or charges drawn by and payable to the order of American Integrity Life insurance Company, Hot Springs, AR, provided there are sufficient collected funds or credit available in said account to pay the same upon presentation. It will not be necessary for any officer or employee of American Integrity Life Insurance Company to sign such checks or charges. I agree that your rights in respect to each such check or charge shall be the same as if it were a check or charge drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and have had adequate time to act on it. I agree that you will be fully protected in honoring such check or charge. I further agree that if any such check or charge be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Bank Account/Preauthorized Transfer **OR** Credit/Debit/Direct Express Card

Bank Account Number	Card Number	
Routing Number	Expiration Date (mm/yy)	CVV *
Bank Name	Visa ☐ MC ☐ Amex ☐ Disc. ☐ Direct Exp. ☐	

*CVV is 3 digits on back of Visa/MC, or 4 digits on front of Amex.

Full Name on Account			
Billing Address	City	State	Zip

- ☐ 1st day of the Month
- ☐ 3rd day of the Month
- ☐ 2nd Wednesday of the Month
- ☐ 3rd Wednesday of the Month
- ☐ 4th Wednesday of the Month
- ☐ On the policy issue day
- ☐ Other, please enter a day: _____

Social Security Deposit Dates Table	Benefits Paid On
Birth Date on 1st – 10th	2nd Wednesday
Birth Date on 11th – 20th	3rd Wednesday
Birth Date on 21st – 31st	4th Wednesday
Supplemental Social Security Income (SSI)	1st of Month
Beneficiaries who started receiving Social Security Benefits prior to May 1997 or who are receiving both SSI and Social Security	3rd of Month

If paying from a checking account, please attach a voided check.

Authorized Account Holder's Signature _____ Date Signed (mm/dd/yyyy)

COMPANY REPRESENTATIVE USE ONLY

Mail Policy To: Agent ☐ Insured ☐

Remarks/Requests: _____

Policy Approved: Yes ☐ No ☐ **Policy #** **Effective Date**

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REPLACEMENT NOTIFICATION

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by American Integrity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I certify that this notice was delivered to me on the date indicated.

Applicant's Signature _____ Date Signed (mm/dd/yyyy) _____

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Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you 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, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

American Integrity Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FAIR CREDIT REPORTING ACT NOTICE CONSUMER REPORT PRE-NOTIFICATION

We may make or obtain a consumer report or an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living (no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance).. The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. You may request to be personally interviewed and, when the report is completed you have the right to inspect and receive a copy of it from the consumer reporting agency. Please send your request to: American Integrity Life Insurance Company, Attention: CONSUMER SERVICES, PO Box 22805, Hot Springs, AR 71903-22805.

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We rely heavily on information provided by you. We may also supplement this information from other sources, such as medical professionals or institutions that have treated you or family members covered under your policy, insurance support organizations, other insurance companies to which you have applied, and employers.

Any information you give us regarding your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless you request otherwise, your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about, and to obtain a copy, if you wish, of items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO US, ATTN: CONSUMER SERVICES, P. O. Box 22805, Hot Springs, AR 71903-22805.

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HEALTH INFORMATION AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has records or knowledge of me or my health to give American Integrity Life Insurance Company, its reinsurers or its affiliates any such information. I understand that I am authorizing American Integrity Life Insurance Company to receive my health information and prescription drug usage history. The released information received by American Integrity Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the company. Any information that is disclosed pursuant to this authorization may be re disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information required is necessary for evaluation and underwriting of my application for the insurance I am applying for; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefit; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with American Integrity Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide this authorization to American Integrity Life Insurance Company will result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying American Integrity Life Insurance Company at their Administrative Office: ATTN: CONSUMER SERVICES, PO Box 22805, Hot Springs, AR 71903-22805. I understand that such revocation will not have any effect on actions American Integrity Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative is entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the Policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing . I certify that I have read, or have had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that it is my responsibility to notify the Company of any change in health prior to the Policy delivery, and that the information may be used in the underwriting evaluation process, and could result in the rescission of the Policy.

I understand that no Agent or Broker is authorized to accept risks or pass upon insurability, to make or modify contracts, or to waive any of American Integrity Life Insurance Company's rights, conditions, or requirements. Only an authorized officer of American Integrity Life Insurance Company can do this.

I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I am not being paid cash and have not been promised services as an inducement to enter into this application. This purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life Settlement Company.

I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. Notices. I authorize American Integrity Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction. Protected Medical Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected healthy information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid for 24 months from the date signed.

Primary Physician's Name	Address (U.S. physician required)	Phone Number
Applicant's Signature	Applicant's Printed Name	Date Signed (mm/dd/yyyy)
Witness (Agent) Signature	Producer's Printed Name	Date Signed (mm/dd/yyyy)

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Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you 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, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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We rely heavily on information provided by you. We may also supplement this information from other sources, such as medical professionals or institutions that have treated you or family members covered under your policy, insurance support organizations, other insurance companies to which you have applied, and employers.

Any information you give us regarding your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless you request otherwise, your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about, and to obtain a copy, if you wish, of items of personal information which appear in our files. You also have the right to seek correction of information you believe to be inaccurate.

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We rely heavily on information provided by you. We may also supplement this information from other sources, such as medical professionals or institutions that have treated you or family members covered under your policy, insurance support organizations, other insurance companies to which you have applied, and employers.

Any information you give us regarding your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless you request otherwise, your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

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HEALTH INFORMATION AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has records or knowledge of me or my health to give American Integrity Life Insurance Company, its reinsurers or its affiliates any such information. I understand that I am authorizing American Integrity Life Insurance Company to receive my health information and prescription drug usage history. The released information received by American Integrity Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the company. Any information that is disclosed pursuant to this authorization may be re disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information required is necessary for evaluation and underwriting of my application for the insurance I am applying for; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefit; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with American Integrity Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide this authorization to American Integrity Life Insurance Company will result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying American Integrity Life Insurance Company at their Administrative Office: ATTN: CONSUMER SERVICES, PO Box 22805, Hot Springs, AR 71903-22805. I understand that such revocation will not have any effect on actions American Integrity Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative is entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the Policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing . I certify that I have read, or have had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that it is my responsibility to notify the Company of any change in health prior to the Policy delivery, and that the information may be used in the underwriting evaluation process, and could result in the rescission of the Policy.

I understand that no Agent or Broker is authorized to accept risks or pass upon insurability, to make or modify contracts, or to waive any of American Integrity Life Insurance Company's rights, conditions, or requirements. Only an authorized officer of American Integrity Life Insurance Company can do this.

I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I am not being paid cash and have not been promised services as an inducement to enter into this application. This purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life Settlement Company.

I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. Notices. I authorize American Integrity Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction. Protected Medical Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected healthy information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid for 24 months from the date signed.

Primary Physician's Name	Address (U.S. physician required)	Phone Number
Applicant's Signature	Applicant's Printed Name	Date Signed (mm/dd/yyyy)
Witness (Agent) Signature	Producer's Printed Name	Date Signed (mm/dd/yyyy)

AMERICAN INTEGRITY
LIFE INSURANCE COMPANY

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email: admin@ailic.com web: www.ailic.com

REPLACEMENT NOTIFICATION

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by American Integrity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I certify that this notice was delivered to me on the date indicated.

Applicant's Signature

Date Signed (mm/dd/yyyy)

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IMPORTANT INFORMATION

If you have questions about your policy or a claim you have filed, please contact us.

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Email: admin@ailic.com

Toll Free Telephone number (866) 524-5433
Fax number (888) 332-5144

If we at American Integrity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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LIMITED BENEFIT HEALTH COVERAGE
HOSPITAL INDEMNITY POLICY

OUTLINE OF COVERAGE

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY.

LIMITED BENEFIT HEALTH COVERAGE - Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

BENEFITS

We will pay the benefits of the Policy described below in the amounts shown provided the treatment, services or supplies:

1. Are prescribed by a Physician as necessary to treat a Sickness or Injury;
2. Are provided at a charge or legal obligation to the Insured to pay;
3. Would routinely be paid in the absence of insurance;
4. Are not received from any member of Your immediate family;
5. Are not received outside the United States; and
6. Are incurred while the Policy is in force.

Hospital Confinement Benefit. We will pay the Hospital Confinement Daily Benefit (Option for $100 to $500 per day, in increments of $50) for each day You are Confined in a Hospital for a covered Injury or Sickness. The Daily Benefit will be payable up to the Maximum Benefit Period per Period of Confinement (Option for 1; 2; 3; 4; 5; 6; 7; 8; 9; 10 days). For benefits to be payable, You must have been charged room and board by the Hospital for each day of Hospital Confinement.

If the Policy terminates during such Hospital Confinement for which benefits are being paid under the Policy, We will continue to pay this benefit until the earlier of:

1. The date You are discharged from the Hospital (regardless of any Hospital re-admission); or
2. The date benefits have been paid for the Maximum Benefit Period per Period of Confinement.

Durable Medical Equipment Benefit. We will pay the Durable Medical Equipment Benefit Amount of $200 per occurrence per Calendar Year for expenses incurred for Durable Medical Equipment due to a covered Injury or Sickness. This benefit is limited to one benefit per Calendar Year and is subject to the Lifetime Maximum Benefit Amount for this benefit of $2,000.

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Ambulance Benefit. We will pay the Ambulance Benefit Amount of $100 per trip per Confinement if a licensed ground or air ambulance service transports You to or from a Hospital where You are Confined due to a covered Injury or Sickness. Any ambulance service must be necessary to protect Your health and safety when other reasonable and customary travel methods are not available. This benefit is limited to one ambulance trip per Hospital Confinement and is subject to the Lifetime Maximum Benefit Amount of $2,500.

Emergency Room Benefit. We will pay the Emergency Room Benefit Amount of $100 per Injury or Sickness for services You receive in a Hospital Emergency Room or a Hospital affiliated emergency care facility due to an Injury or Sickness, provided the emergency treatment is followed within 24 hours by a covered Hospital Confinement of at least one day. One day means a continuous 24-hour period. This benefit is payable only once per Injury or Sickness.

Physician Visit Benefit. We will pay the Physician Visit Benefit Amount of $25 per visit for visits to a Physician. Wellness visits are not covered under this benefit. This benefit is subject to the Calendar Year Maximum Benefit Amount of $50.

Optional Benefit Rider for Outpatient Surgery. We will pay the Outpatient Surgery Benefit Amount of $250 per surgery for surgery performed on You in a Physician's office, clinic, Ambulatory Surgical Center or outpatient Hospital facility due to a covered Injury or Sickness. This benefit is subject to the Lifetime Maximum Benefit Amount of $2,000.

EXCLUSIONS AND LIMITATIONS

Exclusions

The Policy (including any Rider(s) attached) does not pay benefits for conditions caused by or resulting from:

1. Mental, nervous, psychotic or psychoneurotic Sickness or disorder;
2. War or any act of war, whether declared or undeclared, or resulting from service in the armed forces of any country;
3. Committing or attempting to commit an assault or felony or participating in a riot or civil commotion;
4. Attempted suicide or intentionally self-inflicted Injury, whether You are sane or insane;
5. Treatment provided in a U.S. government facility where there is no charge to You;
6. Cosmetic surgery other than:
   a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; or
   b. Reconstructive surgery because of a congenital disease or anomaly;
7. Being legally intoxicated as defined by the jurisdiction in which the Injury occurs; or
8. Voluntary use of any drug, narcotic or controlled substance, unless as prescribed by Your Physician.

Pre-Existing Conditions Limitation

The Policy does not cover Pre-Existing Conditions whether disclosed in the application or not, for the first 6 months beginning on the Policy Effective Date.

RENEWABILITY - You have the right to renew the Policy if You pay the correct premium when due or within the Grace Period.

PREMIUMS - We have the right to change the premium rates on the Policy. We will provide 30 days advanced notice of changes in premium rates.

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I understand that the information required is necessary for evaluation and underwriting of my application for the insurance I am applying for; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefit; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with American Integrity Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide this authorization to American Integrity Life Insurance Company will result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying American Integrity Life Insurance Company at their Administrative Office: ATTN: CONSUMER SERVICES, PO Box 22805, Hot Springs, AR 71903-22805. I understand that such revocation will not have any effect on actions American Integrity Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative is entitled to a copy of this authorization.

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I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. Notices. I authorize American Integrity Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction. Protected Medical Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected healthy information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

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