

UNITED AMERICAN ACCIDENT COMPENSATION PLAN UA-250

Pays Cash Benefits for Accidental Injury . . .

Choose: 1. Lump Sum

OR

2. Hospital Stay Benefit

. . . with Accidental Death Benefit

- ◆ Issue ages 0-63
- ◆ No reduction in benefits for change of occupation
- ◆ Full 24 hours coverage – on or off the job
- ◆ Air travel included
- ◆ Worldwide coverage

ACCIDENT COMPENSATION PLAN

MARYLAND, MICHIGAN

Policy Form UA-250

Choose the "Cash Benefit" most beneficial to YOU.

1. Lump Sum Payment . . . up to \$10,000 per accident

Pays cash as specified for an accidental injury in the Schedule of Benefits screened below. If multiple injuries occur in one accident, this plan pays the *highest* incurred injury amount.

- Benefits increased 50% for accidental injury resulting in a complete open or compound fracture . . . that's ONE-AND-ONE-HALF TIMES the amount for a simple fracture.
- Double Benefits apply for accidental injury resulting in an open operation with bone graft or metallic fixation . . . that's TWO TIMES the amount for a simple fracture.
- Other Injuries ... For other accidental injuries not listed on the Schedule of Benefits, you will receive payment as described under 2. below while hospital confined.

For loss of:		For Complete Dislocation of:	
Both Eyes	\$ 10,000	Two or more Toes.....	\$ 100
One Eye.....	\$ 3,750	One Finger	\$ 50
For Amputation or Severance of:		One Toe	\$ 50
Both Hands or Both Arms	\$ 10,000	For Complete Simple or Closed Fracture of Bone or Bones of:	
Both Feet or Both Legs.....	\$ 10,000	Skull (except bones of face or nose)	\$ 1,300
One Hand or Arm and One Foot or Leg	\$ 10,000	Hip, Thigh (Femur).....	\$ 1,200
One Hand or One Arm	\$ 5,000	Pelvis (except Coccyx)	\$ 1,000
One Foot or One Leg	\$ 5,000	Arm, between Elbow and Shoulder (shaft).....	\$ 800
One or more entire Toes	\$ 800	Shoulder Blade (Scapula)	\$ 800
One or more entire Fingers	\$ 600	Leg (Tibia or Fibula).....	\$ 800
For Complete Dislocation of:		Ankle	\$ 600
Hip Joint	\$ 1,200	Knee Cap (Patella)	\$ 600
Knee Joint (except Patella)	\$ 600	Collar Bone (Clavicle)	\$ 600
Bone or Bones of the Foot, other than Toes	\$ 600	Forearm (Radius or Ulna).....	\$ 600
Ankle Joint	\$ 600	Foot (except Toes)	\$ 500
Wrist Joint.....	\$ 500	Hand or Wrist (except Fingers)	\$ 500
Elbow Joint.....	\$ 400	Lower Jaw (except Alveolar Process).....	\$ 300
Shoulder Joint.....	\$ 300	Two or more Ribs, Fingers or Toes	\$ 200
Bone or Bones of the Hand, other than Fingers	\$ 200	Bones of Face or Nose	\$ 200
Collar Bone.....	\$ 200	One Rib, Finger or Toe	\$ 100
Two or more Fingers.....	\$ 100	Coccyx.....	\$ 100

– OR –

2. Hospital Cash Benefit . . . up to \$6,250 per hospital stay

Pays \$250 per week (pro-rated \$35.71 per day) for as long as 25 weeks while confined in the hospital due to accidental injury.

Accidental Death Benefit — \$10,000

Pays \$10,000 upon an accidental injury resulting in the death of any covered person instead of all other benefits (or \$10,000 minus any previously paid benefit) to your estate – or to the person you name as beneficiary on your application.

1. Lump Sum
Benefit Example: = previous \$1,300 paid for skull fracture \$8,700 death benefit

1. Hospital Cash
Benefit Example: = previously up to \$6,250 paid hospital benefit up to \$3,750 death benefit

FIRST AID BENEFITS — Pays incurred expenses up to \$40 for medical treatment in the doctor's office or at the hospital when special outpatient treatment is required due to accidental injury and no other benefit.

LIMITATIONS AND EXCLUSIONS . . . This policy does not cover accidents, injuries, death, disability or other loss caused by: **1.** Sickness or disease in any form; **2.** Insanity or mental derangement; **3.** Intentionally self-inflicted injuries while sane or insane; **4.** Suicide or attempt thereof while sane or insane; **5.** War or any act of war; or **6.** Any loss incurred while engaged in military or naval service of any country. No benefits payable for confinement at any veteran's hospital or any government hospital where no legal liability exists for services rendered.
EFFECTIVE DATE OF COVERAGE . . . INJURY occurring after policy effective date is covered.

CONGRATULATIONS ON YOUR GOOD JUDGEMENT!
MAKE CHECK PAYABLE TO COMPANY, not to an individual.

Received of _____ the sum of \$_____ for _____ months premium, other policy fees and noninsurance charges with application for Policy Form UA-250. If for any reason policy is not issued, payment is to be refunded in full.

Date

Authorized Agent Signature

Keep this Page . . . it highlights the benefits of your policy. It is not a contract. Your actual policy provisions will govern your benefits.

UNITED AMERICAN INSURANCE COMPANY
P.O. Box 8080 • McKinney, Texas 75070 • (972) 529-5085
www.unitedamerican.com

APPLICATION FOR ACCIDENT EXPENSE INSURANCE

PLAN APPLIED FOR _____ INDIVIDUAL PLAN ONLY..... <input type="checkbox"/> FAMILY PLAN..... <input type="checkbox"/>	TOTAL INITIAL PREMIUM \$ _____ AMOUNT PAID \$ _____ MODE: <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY <input type="checkbox"/> MONTHLY	PAYMENT METHOD <input type="checkbox"/> SEND PREMIUM NOTICES <input type="checkbox"/> AUTOMATIC PAYMENT PLAN	SPECIAL INSTRUCTION
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SCHEDULE A			DATE OF BIRTH			
NAMES OF PERSONS PROPOSED FOR INSURANCE	SEX	RELATIONSHIP	MO.	DAY	YR.	AGE

SEND PREMIUM NOTICE TO:	Name	Applicant's Phone No.
	Street Address	Full Name of Beneficiary for Applicant
	City State Zip	Relationship

Will this policy replace any existing coverage?..... ☐ Yes ☐ No

If yes, give company name _____ Policy Number _____

Applicant's Occupation _____ Spouse's Occupation _____

Any Part time Occupation?

If yes, explain: _____

Does Applicant engage in any hazardous sports or avocation?..... ☐ Yes ☐ No

If yes, explain: _____

To the best of your knowledge and belief, are you and all persons proposed for insurance listed under Schedule A free from any physical or mental impairment, deformity, impairment of vision or hearing? ☐ Yes ☐ No

If no, give details: _____

I understand the policy must be issued to place coverage in force.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the complete application and the applicant understands that any false statement or misrepresentation therein may result in loss of coverage under this policy.

AUTHORIZATION – I hereby authorize any physician, medical practitioner, hospital, clinic, or other medically related facility or person that has any records or knowledge about me or my health to give information to the United American Insurance Company.

I certify: (1) I have accurately recorded the information supplied by the applicant, and (2) I have given an Outline of Coverage for the policy applied for to the applicant.

Dated at _____
(city and state)

Agent's Signature _____ Agt. No. _____ This _____ day of _____
(month) (year)

(Print Agent's Name)

Applicant's Signature

UNITED AMERICAN'S ACCIDENT COMPENSATION PLAN UA-250 RATES

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
INDIVIDUAL	\$100	\$52	\$27	\$ 8
FAMILY	\$180	\$94	\$48	\$15

Registration Fee: \$6 to be paid with each policy in addition to the initial premium.

Eligible Members: The insured and the spouse, age 18 through 63, and any unmarried dependent children under 21 years of age, or, under age 24 if attending a university, vocational or technical school.

AUTOMATIC PAYMENT PLAN AUTHORIZATION

All premiums will be automatically withdrawn from your account on MONTHLY mode unless a different mode is checked in the box below.

☐ QUARTERLY ☐ SEMI-ANNUAL ☐ ANNUAL

Date

✓ _____
Signature (as it appears on bank records)

PLEASE READ BEFORE SIGNING AUTHORIZATION ABOVE:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of the United American Insurance Company, McKinney, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits 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.

ATTACH APPLICANT'S
VOIDED
PERSONALIZED CHECK
HERE

UA **United American
Insurance Company**
Since 1947

3700 S. STONEBRIDGE DRIVE • P.O. BOX 8080 • MCKINNEY, TEXAS 75070

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