MONTANA

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

Policy Form UA-250(95)

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 incurred injury amount.

- Benefits increased 50% for accidental injury resulting in an open or compound fracture . . . that's ONE-AND-ONE-HALF TIMES the amount for simple fractures.
- Double Benefits apply for accidental injury resulting in an open operation with bone graft or metallic fixation . . . that's TWO TIMES the amount for simple fractures.
- 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:	
Both Eyes	$ 10,000
One Eye	$ 3,750
For Amputation or Severance of:	
Both Hands or Both Arms	$ 10,000
Both Feet or Both Legs	$ 10,000
One Hand or Arm and One Foot or Leg	$ 10,000
One Hand or One Arm	$ 5,000
One Foot or One Leg	$ 5,000
One or more entire Toes	$ 800
One or more entire Fingers	$ 600
For Complete Dislocation of:	
Hip Joint	$ 1,200
Knee Joint (except Patella)	$ 600
Bone or Bones of the Foot, other than Toes	$ 600
Ankle Joint	$ 600
Wrist Joint	$ 500
Elbow Joint	$ 400
Shoulder Joint	$ 300
Bone or Bones of the Hand, other than Fingers	$ 200
Collar Bone	$ 200
Two or more Fingers	$ 100

For Complete Dislocation of:	
Two or more Toes	$ 100
One Finger	$ 50
One Toe	$ 50
For Complete Simple Fracture of Bone or Bones of:	
Skull (except bones of face or nose)	$ 1,300
Hip, Thigh (Femur)	$ 1,200
Pelvis (except Coccyx)	$ 1,000
Arm, between Elbow and Shoulder	$ 800
Shoulder Blade (Scapula)	$ 800
Leg (Tibia or Fibula)	$ 800
Ankle	$ 600
Knee Cap (Patella)	$ 600
Collar Bone (Clavicle)	$ 600
Forearm (Radius or Ulna)	$ 600
Foot (except Toes)	$ 500
Hand or Wrist (except Fingers)	$ 500
Lower Jaw (except Alveolar Process)	$ 300
Two or more Ribs, Fingers or Toes	$ 200
Bones of Face or Nose	$ 200
One Rib, Finger or Toe	$ 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***

2. 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 thereat 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(95). 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

United American Insurance Company
Since 1947
McKinney, Texas

APPLICATION FOR
ACCIDENT EXPENSE INSURANCE

PLAN APPLIED FOR _____	TOTAL INITIAL PREMIUM $_____	PAYMENT METHOD	SPECIAL INSTRUCTION
INDIVIDUAL PLAN ONLY. . . . . ☐	AMOUNT PAID $ _____	☐ SEND PREMIUM NOTICES	
FAMILY PLAN. . . . . ☐	MODE: ☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY	☐ AUTOMATIC PAYMENT PLAN	

SCHEDULE A

NAMES OF PERSONS PROPOSED FOR INSURANCE	SEX	RELATIONSHIP	DATE OF BIRTH MO.	DAY	YR.	AGE

SEND PREMIUM NOTICE TO:

Name _____

Street Address _____

City _____ State _____ Zip _____

Applicant's Phone Number _____

Full Name of Beneficiary for Applicant _____

Relationship _____

MONTANA

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? ☐ YES ☐ NO

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)

This _____ day of _____ _____

_____
Agent's Signature Agt. No.

_____
(Print Agent's Name)

_____
Applicant's Signature

U5201-95

MAIL POLICY TO: ☐ AGENT ☐ APPLICANT

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: $6.00 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 18 years of age.

AUTOMATIC PAYMENT PLAN AUTHORIZATION

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

☐ **QUARTERLY** ☐ **SEMI-ANNUAL** ☐ **ANNUAL**

_____ ✓ _____

Date Signature **(as it appears on bank records)**

ATTACH APPLICANT'S **VOIDED PERSONALIZED CHECK** HERE

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.

UA United American Insurance Company
Since 1947
P.O. BOX 8080 • McKINNEY, TEXAS 75070