

(239) 466-4466



ACCIDENTAL LIFE INSURANCE TO PROTECT YOUR FAMILY

The Top Five Causes of Unintentional Death are*:



Motor Vehicle



Falls



Choking



Drowning



Poison

Accidental LIFE INSURANCE Policy (Issue Ages 18-68)

\$3,000

Coverage for you

\$1,000

Coverage for each child

Only \$10/yr.

Important Facts*

- Accidents are the leading cause of death among those 1 to 44 years old and the fifth leading cause of death overall.
- An estimated 161,374 Americans were killed by unintentional injury in 2016.
- An accidental death occurs every four minutes in the United States.

UA **United American Insurance Company**
Since 1947

(239) 466-4466

Noncancelable and Guaranteed Renewable

with premiums payable to policy anniversary following insured's 70th birthday.

- for \$10 a year premium. If you decide not to pay the premium, the plan will terminate and no premiums will be due.
- Coverage is effective when the named insured or spouse signs the application for insurance. If the spouse signs the application, the named insured must be alive at time of signature.

*Source: National Safety Council's Injury Facts 2017 Edition.

This is only a brief description of United American's Accidental Death Insurance Policy, form UAINADP. See policy for definitions. Noncancelable until the policy anniversary following your 70th birthday. Full details, including exceptions for payment of benefits, are in the policy. Insurance benefits provided by United American Insurance Company, 3700 S. Stonebridge Drive, McKinney, Texas 75070.

UNITED AMERICAN INSURANCE COMPANY
P. O. BOX 8080, MCKINNEY, TEXAS 75070 * (239) 466-4466
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

OUTLINE OF COVERAGE FOR ACCIDENTAL DEATH INSURANCE
For Policy Form Number UAINADP

BENEFITS

PART 1 ACCIDENTAL DEATH

Death must occur within 180 days after the date of the accident.

This policy is an accidental death policy that upon death will pay the Accidental Death Benefit shown in the schedule on page one of the policy when We receive due proof of the accidental death of the insured while the policy is in force.

PART 2 EXCLUSIONS AND LIMITATIONS

The policy does not cover death caused by:

1. Disease, sickness, infection, bodily or mental infirmity, or medical or surgical treatment of same;
2. Suicide or intentionally self-inflicted bodily injury, or any attempt thereat, while sane or insane (reference to insane not applicable in Colorado or Missouri);
3. Voluntary gas inhalation, or poison voluntarily taken, absorbed, inhaled or injected;
4. Service in the military, naval or air services of any country (combat or training exercises);
5. Participation in any organized contest of speed endurance (driving or riding in any race);
6. Operating any motor vehicle for recreational purposes other than on paved roads or surfaces constructed for public use (i.e. off road);
7. Being intoxicated or under the influence of alcohol or any drug or narcotics unless administered on the advice of a physician. Being under the influence of alcohol is that which is determined by the laws of the geographical area in which the Accident occurred;
8. Air travel except as a fare paying passenger on a regularly scheduled flight;
9. Committing or attempting to commit an assault, felony, or any other illegal occupation;
10. Taking part in a riot, insurrection or terrorist act;
11. Skydiving, scuba diving, hang gliding or hot air ballooning; or
12. War, or act of war, whether declared or not.

Benefits will terminate on the Policy Anniversary following the Primary Insured's 70th birthday.

This is a brief outline of the policy applied for and is not the contract of insurance. The policy or contract itself sets forth the rights and obligations of the Insured and insurer.

TO START COVERAGE:
call (239) 466-4466
or fill out the application below

UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY * Administrative Office: McKinney, Texas 75070

Application for Accidental Death Policy

Benefit Amount
\$3,000
(\$3,000 spouse, \$1,000 each child)

☒ **Annual Mode of Premium**
FAX app to 239- 963-3674
or email to APP@LifeGuy.com

Mode of Premium Payment
☒ Send Premium Notices
☐ Automatic Payment Plan
Day (01-28) of the Month
to Draft Bank Account

Proposed Policyholder/Applicant

First Name M.I.

Last Name

Address

City State Zip Code

Age Last Birthday Date of Birth (mm-dd-yyyy) - - Sex ☐ Male
☐ Female

Home Phone No. - - Work Phone No. - -

SS # - - E-mail Address of Proposed Policyholder/Applicant

Beneficiary Name Relationship

Spouse
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 1
First Name M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 2
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 3
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

20679

UAIN-TAP(10)

(Application Continued)

FAX app to 239- 963-3674 or email to APP@LifeGuy.com



UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY * Administrative Office: McKinney, Texas 75070

Application for Accidental Death Policy

Child 4	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		<div style="border: 1px solid black; height: 15px; width: 100%;"></div>
First Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		M.I. <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Last Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		
SS #	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Date of Birth (mm-dd-yyyy)	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Child 5	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		<div style="border: 1px solid black; height: 15px; width: 100%;"></div>
First Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		M.I. <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Last Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		
SS #	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Date of Birth (mm-dd-yyyy)	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Child 6	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		<div style="border: 1px solid black; height: 15px; width: 100%;"></div>
First Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		M.I. <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Last Name	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		
SS #	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Date of Birth (mm-dd-yyyy)	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>

Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the application Replacement Regulation or Rule. ☐ Yes ☒ No **This policy is not to be used to replace other coverage.**

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed policyholder. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed policyholder is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed policyholder.

I, HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB, Inc. may be obtained on its website at www.mib.com.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Date Application
Signed (mm-dd-yyyy) - -
State


Agent's Signature

Signed _____
Proposed Policyholder

Last Name

D R A G A N

 Agent No.

0 1 1 3 2

Signed _____
Applicant (If other than the Proposed Policyholder)

Print First 5 Letters of Agent's Last Name

SEND POLICY TO: ☐ Agent ☒ Policyholder The Policy will be sent to policyholder unless otherwise instructed.

