

HOSPITAL INDEMNITY DISCLAIMER

I accept the insurance elected above. The plan I have elected is a Limited Hospital Indemnity Plan. I understand that I am not electing Major Medical or Comprehensive Medical coverage. If at a later date I wish to participate in coverages I have not elected, I understand that my coverage is subject to the terms and conditions of the Policy and acceptance by the Insurance Company. I understand that the coverage selected will begin on the effective date as described in the brochure. I understand if my family members' named above are not or I am not in Active Service on the date coverage would otherwise be effective, it will be effective on the date my family members or I return to Active Service. However, my family members' coverage will not be in effect prior to the date of my coverage. I authorize and agree to payroll deduction of the required premium.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.

I further understand that I should contact ACE American Insurance Company's representative (Administrative Concepts, Inc.) with any questions I may have concerning the "plan"

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.