PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P. O. Box 4884, Houston, Texas 77210

DISCLOSURE NOTICE

HOSPITAL INDEMNITY INSURANCE POLICY

By my signature affixed hereto, I verify that I have been provided an Outline of Coverage describing the Policy for which I have applied on this date. I verify that the agent representing Philadelphia American Life Insurance Company discussed, in detail, the coverage as explained in the Outline of Coverage. In addition, the agent explained and I understand the following provisions:

1. The coverage for which I have applied will become effective only when the application is approved by the Home Office and only on the Effective Date assigned by the Company.

2. If I am approved and my Policy is issued, my coverage will begin immediately on the assigned Effective Date.

3. No benefits will be payable for any sickness or injury due to a Pre-Existing Condition. Pre-existing Condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

4. I understand that a claim for benefits may not be payable under the new Policy due to the above-mentioned Pre-existing Condition waiting period; whereas, the same claim might have been payable under my present coverage, if any, had it remained in force.

5. I understand that until the coverage has been approved and issued, Philadelphia American Life Insurance Company has absolutely no liability to me other than to refund my initial premium if my Application is not approved. Any injury or sickness which may develop between now (today) and the date my coverage is effective will be a Pre-existing Condition, and depending on extent and severity, such injury or sickness may render me (or a dependent) ineligible for coverage.

6. I have read or have been read to me and answered the questions on my Application on behalf of myself and my dependents. I also understand that disclosure of health information is important and any omission may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed. My Policy, if issued, will contain a photocopy of this document along with the Application for Coverage.

7. I understand that this insurance is not a substitute for comprehensive health insurance coverage and does not qualify as minimum essential health coverage under the Patient Protection and Affordable Care Act.

DATE:_____ APPLICANT'S SIGNATURE: _____

DATE:_____ AGENT'S SIGNATURE: _____