

## Junior Estate Builder



They grow up fast.  
Protect them while you can.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

**Humana** Financial Protection Products

## Junior Estate Builder



Care for the children  
you love by insuring  
their future.

Give the priceless gift of protection. Humana's **Junior Estate Builder** life insurance protects your child or grandchild, now and in the future, by establishing financial security that lasts a lifetime.

### It works like this:

- You'll start out with the protection of term life insurance with low premiums
- At age 25, the policy automatically converts to a whole life policy
- The whole life policy builds cash value with the option to increase coverage

### The plan provides:

- ✓ **Affordability** – Low annual premium.\*
- ✓ **No-risk, no hassles** – No medical exam or interview.  
Plus you can return the policy within 30 days for a full refund.
- ✓ **Flexibility** – Additional coverage can be purchased at ages 25, 28, and 31 without evidence of insurability.  
From a \$20,000 policy you can increase up to a total of \$80,000 of whole life coverage.
- ✓ **An investment in their future** – Policy generates monetary values that may provide cash in the future.\*\*

### You choose the plan that's right for you:

Plan Option	Coverage Amount	Locked-in Annual Premium
Plan One	\$15,000 coverage	Only \$35 / year
<b>Plan Two – BEST VALUE!</b>	<b>\$20,000 coverage</b>	<b>Only \$45 / year</b>

**HUMANA**  
Guidance when you need it most

Junior Estate Builder is Kanawha Insurance Company policy Form 20305 1/88. Benefits may vary by state and may not be approved in all states. Limitations and exclusions apply. Please see actual policy for complete details. Underwritten by Kanawha Insurance Company – a member of the Humana family of companies. Available for ages 0 - 24 years (nearest age).

\*At age 25 there is a one-time premium increase upon conversion from term to whole life.

\*\* Monetary value accumulations begin after the policy converts to whole life at age 25.

## Application for Junior Estate Builder

**Check the plan applying for:**

**Plan 20305** — Face Amount \$15,000  
Annual Premium \$35

**Plan 20306** — Face Amount \$20,000  
Annual Premium \$45

**Kanawha Insurance Company**  
210 South White Street  
Post Office Box 7777  
Lancaster, South Carolina 29721-7777

Producer Number \_\_\_\_\_

Proposed Insured(s)*	Home Office Use Policy Number	State of Residence	Sex M/F	Age	Date of Birth	State of Birth	Height	Weight
①								
②								
③								

\*Proposed Insured(s) referred to as you or your.

	① Yes No	② Yes No	③ Yes No
1. Within the past 7 years has Proposed Insured:			
a. Been diagnosed or treated for heart disease or any abnormalities of the heart, diabetes, kidney disease, anemia, immunodeficiency disease or disorder by a member of the medical profession? _ _ _ _ _	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
b. Had any health, mental or physical impairment or been excused from any physical activities at school because of medical reasons? _ _ _ _ _	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. Within the past 3 years has Proposed Insured been confined in a hospital? _ _ _ _ _	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
3. Is Automatic Premium Loan desired? _ _ _ _ _	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4. Will the policy applied for replace or change any policy in force with any company? _ _ _ _ _ Give company name, policy number, date of issue, and amount. Complete replacement form.	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Give details of "Yes" answers to questions 1 and 2. Include names and addresses of physicians, medical practitioners, hospitals, and clinics.

Proposed Insured(s)	Date, Reason, Medications, Physicians, Medical Practitioners, Hospitals, and Clinics

Beneficiary	Relationship

**Please complete front and back of this application.**

The undersigned applicant and producer agree that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any false statements or misrepresentations in the application may result in the loss of coverage as stated in the Incontestability Provision of the policy. If your answers on this application are incorrect or untrue, Kanawha Insurance Company may have the right to deny benefits or to rescind your policy.

**Authorization:** I authorize Kanawha and its reinsurers to obtain information as to the diagnosis or treatment of my or my child's physical and/or mental condition and any other information needed to determine eligibility for insurance. Upon presentation of this authorization, or a photocopy of it, which is valid for 26 months from the date shown below, Kanawha or its reinsurers may obtain information or records thereof from any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, employer, consumer reporting agency or the Medical Information Bureau, that has any records of me or my child for whom insurance application is made, or my health or my child's health, to give to Kanawha or its reinsurers any such information and to testify to such information, all to the extent permitted by law. I realize that I, or a representative on my behalf, have the right to receive a copy of this authorization.

**Caution:** 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 subject to prosecution and punishment for insurance fraud.

I acknowledge that I have received a copy of the Notice to the Proposed Insured and the Medical Information Bureau Disclosure Notice which was attached to this application.

Dated at \_\_\_\_\_ Date \_\_\_\_\_  
City/State

X \_\_\_\_\_  
Signature of Owner Relationship to Proposed Insured Social Security Number of Owner

X \_\_\_\_\_  
Printed Name of Owner

Address \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Within City Limits  Yes  No

X \_\_\_\_\_ X \_\_\_\_\_  
Signature(s) of any Proposed Insured(s) if age 15 or over Signature of Licensed Resident Producer

**Producer's Certification**

To the best of my knowledge, replacement is  is not  involved. I hereby certify that I have truly and accurately recorded on the application the information supplied by the applicant.

\_\_\_\_\_  
Signature of Licensed Resident Producer Printed Name of Licensed Resident Producer Producer's License # or Code

All premium checks *must* be made payable to Kanawha Insurance Company. *Do not* make check payable to the producer or leave the payee blank.

**Billing Instructions:**  Bill all policies to Owner/Applicant  
 Bill each policy separately as follows:

**Proposed Insured** ① \_\_\_\_\_

**Proposed Insured** ② \_\_\_\_\_

**Proposed Insured** ③ \_\_\_\_\_