

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes. Answer all questions, then sign the Agreement and Authorization.

**Section 1: Member Information**

1. Member Name: \_\_\_\_\_
2. Member's SSN: \_\_\_\_\_
3. Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 6. Place of Birth: \_\_\_\_\_ 7. Citizenship/Country: \_\_\_\_\_
8. Sex:  Male  Female 9. Daytime Phone #: \_\_\_\_\_
10. Are you a member of the National Association of Professional Insurance Agents?  Yes  No
11. Current Occupation/Profession: \_\_\_\_\_ 12. How many hours a week do you work? \_\_\_\_\_
13. Please describe your duties: \_\_\_\_\_
14. Beneficiary: \_\_\_\_\_ 15. Relationship of Beneficiary to you: \_\_\_\_\_
16. Application is made for:  New Coverage  
 Increase Current Amount of Coverage: \$ \_\_\_\_\_  
 Reinstatement following military service. Dates of service: from \_\_\_\_\_ to \_\_\_\_\_  
Amount of Coverage: \$ \_\_\_\_\_

**Section 2: Plan Selection for Business Overhead Expense Coverage**

1. MAXIMUM MONTHLY BENEFIT: \$ \_\_\_\_\_ (\$500 to \$10,000 per month, in increments of \$500, not to exceed 100% of your Monthly Insurable Expenses. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.)
2. MAXIMUM BENEFIT PERIOD: (Select one)  12 Months  18 Months  24 Months
3. ELIMINATION PERIOD: 30 Days

**Section 3: Other Coverage**

If You have Disability Income or Business Overhead Expense insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?	Employer Paid
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Section 5: Member's Statement of Health — Continued**

f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system? (In ME and WI, excluding HIV) <input type="checkbox"/> Yes <input type="checkbox"/> No	i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No
g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No	j) chronic fatigue, Epstein Barr virus, fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
	k) complications of pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No
h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	l) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", due date: _____

7. During the past 10 years (5 years in IN and KS) have you had, or been told you have, or been treated for a disease or disorder of the blood? (In ME, excluding HIV)  Yes  No  
A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)
8. During the past 10 years (5 years in IN and KS) have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (In ME, excluding HIV)  Yes  No
9. During the past 10 years (5 years in IN and KS) have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital? (In ME, excluding HIV)  Yes  No
10. Are you presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason?  Yes  No
11. During the past 10 years (5 years in IN and KS) have you:
- a) sought, been advised to seek, or received counseling or treatment for the use of alcohol?  Yes  No
  - b) used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received counseling or treatment for the use of prescribed or non-prescribed drugs; or ever been arrested for the possession of or use of prescribed or non-prescribed drugs?  Yes  No
  - c) been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No

**If you are a resident of CA, CO, ME, ND, NJ or WI do not answer question 12.**

12. During the past 10 years (5 years in IN and KS) have you tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?  Yes  No

**Section 6. Medical Details (Please provide details if you answered YES to any item in the Member's Statement of Health Section:**

Question #	Reason/Condition	Diagnosis/Treatment/Results	Name, Address & Phone No. of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work

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**Section 7: Fraud Notice**

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**The following Notice applies to residents of NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**The following Notice applies to residents of NY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

**The following Notice applies to residents of AR, LA, MN, NM, VA, and WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, civil and criminal penalties.

**The following Notice applies to residents of all other states:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

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**Section 8: Agreement and Authorization**

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I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that, subject to the policy's Deferred Effective Date provision, coverage will not become effective until Unimerica Insurance Company ("Unimerica") grants its underwriting approval.

I understand that any condition which is excluded under the Policy will not be covered at any time.

I hereby authorize Unimerica to give information about me to any organization administering the coverage for which I am applying or as required by law. I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, to give Unimerica and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance.

I understand that I may revoke this authorization at any time by sending a written revocation to Unimerica at the address below. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right Unimerica has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate.

I understand that if I revoke this authorization, Unimerica may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws.

I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

Member Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

The following additional notice applies *only* to residents of *Maine*: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS/ARC. Residents of Maine should also note that failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

**Retain a photocopy of this application for your records and return the original to:**  
**Lockton Risk Services**  
**P.O. Box 410679 • KansasCity, MO 64141--0679**  
**Phone: 800--336--4759 • Fax: 913--652--7599**