

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: Applicant Information**

1. Applicant Name: \_\_\_\_\_ 2. Applicant's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
3. Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 6. Place of Birth: \_\_\_\_\_ 7. Citizenship:  US  Other: \_\_\_\_\_
8. Sex:  Male  Female 9. Daytime Phone #: \_\_\_\_\_
10. Your Membership affiliation:  PIA Member  Employee of a PIA Member or PIA Member Agency  
 Officer or Employee of PIA National  Officer or Employee of PIA Regional Affiliate  
 Other (specify): \_\_\_\_\_
11. If an employee, please provide the name of the Member or Member Agency: \_\_\_\_\_
12. Current Occupation: \_\_\_\_\_ 13. How many hours per week do you work? \_\_\_\_\_
14. Please describe your duties: \_\_\_\_\_
15. Beneficiary: \_\_\_\_\_ 16. Relationship of Beneficiary to you: \_\_\_\_\_
17. 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 Disability Income Coverage**

1. MAXIMUM MONTHLY BENEFIT: \$ \_\_\_\_\_ \$200 to \$8,000 per month, in increments of \$100, not to exceed 60% of your Monthly Insurable Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.
2. MAXIMUM BENEFIT PERIOD: (Select one)  2 Years  5 Years  To Age 65
3. ELIMINATION PERIOD: (Select one)  90 days  180 days
4. OPTIONAL BENEFITS: (Select Option desired)  Cost of Living Adjustment  
 Catastrophic Disability Coverage: \$200 to \$3,200 per month, in increments of \$100, not to exceed 40% of your monthly insurable income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.

**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

**Section 4: Financial Information**

1. Business Type (check one):  Proprietorship  Partnership  Corporation  Limited Liability Partnership  
 Limited Liability Corporation  S-Corporation  Other (specify): \_\_\_\_\_
2. Percentage of business owned by you: \_\_\_\_\_ Number of years owned by you: \_\_\_\_\_  
Number of years business has been in existence: \_\_\_\_\_
3. Annual earned income from your personal services as reported to the IRS on your personal and/or business federal tax return:  
Last Calendar Year: \$ \_\_\_\_\_ Prior Calendar Year: \$ \_\_\_\_\_

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**Section 5: 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 6: 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 Pre-Existing Condition Limitation and Deferred Effective Date provisions, 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 understand that any pre-existing condition (including any injury, sickness, mental illness or substance abuse) for which: (a) I was diagnosed or received treatment from a physician or other licensed practitioner of the healing arts; or (b) I took any drugs or medications; within the 12 month period prior to my effective date of insurance, will not be covered until the earlier of: (1) the date I have been insured under the policy for 24 months after my Effective Date; or (2) the date I have been free of treatment for such condition for a one year period ending on or after my Effective Date. Except in ID, ME, and MO, I further understand that pre-existing conditions include any symptoms or subjective symptoms that I had within the 12 month period prior to my Effective Date.

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.

Applicant 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 • Kansas City, MO 64141-0679 • Phone: 800-336-4759 • Fax: 913-652-7599**