

Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828 • Portland, Maine 04112-8828

Short Term Disability Income Insurance Application
PIA Services Group Insurance Fund
Group Policy Number: 1058

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: \$ _____ \$100 to \$1,500 per month, in increments of \$100, not to exceed 75% of your Monthly Insurable Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.
2. MAXIMUM BENEFIT PERIOD: 30 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 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: \$ _____

Section 5: Applicant's Statement of Health:

1. a) Height ___ ft. ___ in. b) Weight _____ lbs. c) Weight change last year: _____ lbs.
 d) Reason for weight change: (Gain or Loss) _____
2. Name of Personal Physician (if none, please indicate): _____
 Physician Address: _____
 Date last seen: _____ Reason: _____ Results: _____
3. In the past 180 days, have you ever been:
 a) absent from work, or unable to perform any duty of your occupation, because of sickness or injury? Yes No
 b) been homebound or hospitalized because of sickness or injury? Yes No
 If Yes to a) or b), for how many days? _____ Date(s): _____ Reason: _____
4. Have you used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe within the last 12 months? Yes No
5. During the past 10 years (5 years in IN and KS) have you ever engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? Yes No
6. During the past 10 years (5 years in IN and KS) have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details. Except in KS, include conditions for which you have experienced symptoms.

a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung? <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 HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder? <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
d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition? <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
	j) chronic fatigue, Epstein Barr virus, fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	k) complications of pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No
	l) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", due date: _____

Section 5: Applicant's Statement of Health — Continued

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 applicant of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (In ME, excluding HIV) 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 Applicant'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

Section 7: Fraud Notice

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.

Section 7: Fraud Notice – Continued

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.

Section 8: Agreement and Authorization

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