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

Basic Life Insurance Application/Enrollment Form
PIA Services Group Insurance Fund
Group Policy Number: 1051

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/Employee Information

1. Member/Employee Name: ______________________________

2. Member/Employee'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. Your PIA affiliation (check one):

CLASS 1

- ❑ Individual proprietors, partners, corporate officers, limited liability partners and managers of member Agencies who are principally engaged in the business of the Member Agency and who maintain current membership status in the National Association of Professional Insurance Agents;
- ❑ Trustees of PIA Services Group Insurance Fund who maintain current membership status in the National Association of Professional Insurance Agents;
- ❑ Persons employed as executive directors, department heads, division heads, or senior staff of the National Association of PIA, a local PIA affiliate, or PIA Services, Inc.; and
- ❑ Trust manager of PIA Services Group Insurance Fund.

CLASS 2

- ❑ Licensed employees of Member Agencies; and
- ❑ Independent Producers who:
  - a) work exclusively for a Member Agency;
  - b) maintain current membership status in the National Association of Professional Insurance Agents;
  - c) receive from the Member Agency a monthly commission which, when combined with any draw against commission, equals an amount not less than minimum wage times 150 hours; and
  - d) are certified by the Member Agency as working at least 20 hours per week.

CLASS 3: All other employees of:

- ❑ a Member Agency;
- ❑ PIA Services Group Insurance Fund;
- ❑ National Association of Professional Insurance Agents or its local affiliates; and
- ❑ PIA Services, Inc.

11. If an employee, please provide the name of the Member or Member Agency: ______________________

12. Current Occupation: ______________________

13. Please describe your duties: ______________________

14. How many hours per week do you work? ______________________

15. 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 Life Coverage

1. Amount of Life Insurance Desired: $__________(Class 1 $50,000; Class 2 $30,000; Class 3 $20,000) (If applying to increase coverage, indicate only the ADDITIONAL amount of Life Insurance desired.)
2. Full Name of Beneficiary: ______________________________ Relationship: ________________
3. Full Name of Contingent Beneficiary: __________________________ Relationship:________________
4. Life Insurance for Dependent Spouse: ❑ Yes ❑ No If yes, please complete the Spouse Life Insurance Application.
5. Life Insurance for Dependent Children: ❑ Yes ❑ No Amount of Life Insurance for Dependent Children: $3,000 ($500 for age 14 days to 6 months).
6. Names and Birth Dates of Dependent Children (if Covered):

Name of Child	/ Date of Birth	Name of Child	/ Date of Birth
	/		/
	/		/
	/		/

Section 3: Fraud Notice

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.

Section 4: 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 deferred effective date provision, coverage will not become effective until Unimerica grants its underwriting approval. I understand that any condition which is excluded under the Policy will not be covered at any time.

Although group disability income insurance is not subject to Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), some individuals / organizations will require a HIPAA conforming authorization to release information. I understand the following authorization is intended to conform to HIPAA standards.

I hereby authorize insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of my 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: ______________________

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