

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. If an employee, please provide the name of the Member or Member Agency: _____
11. Your PIA affiliation (check one):

<input type="checkbox"/> Individual proprietor, partner, corporate officer, limited liability partner or manager of member Agencies <input type="checkbox"/> Trustee of PIA Services Group Insurance Fund <input type="checkbox"/> Executive director, department head, division head, senior staff of the National Association of PIA, a local affiliate, or PIA Services, Inc.	<input type="checkbox"/> Licensed employee of Member Agency <input type="checkbox"/> Independent Producer <input type="checkbox"/> Other employee of Member Agency; PIA Services, Inc., PIA Services Group Insurance Fund or National Association of PIA or its local affiliates <input type="checkbox"/> Other (specify): _____
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12. Current Occupation: _____ 13. How many hours a week do you work? _____
14. Please describe your duties: _____
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: \$ _____ \$10,000 to \$300,000 in \$10,000 units. (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: Member/Employee'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 10 years, 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. In the past 10 years have you ever engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? Yes No

6. In the past 10 years have you ever been medically diagnosed as having, experienced symptoms of or been treated for: (indicate Yes/No and give details under Medical Details)

a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system, blood or blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No	f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or disorder of the blood or immune system? <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 Human Immunodeficiency Virus)? <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: _____

7. In the past 10 years have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? Yes No

8. In the past 10 years 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? Yes No

9. 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

Section 5: 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 6: 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 life 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 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: _____

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**