

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.

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**Section 1: Spouse Information**

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**IMPORTANT NOTE: A Spouse is only eligible for coverage if the Member/Employee is covered.**

1. Spouse Name: \_\_\_\_\_
2. Spouse 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. Please enter the Member or Employee's Name: \_\_\_\_\_
11. Application is made for:  New Coverage  
 Increase Current Amount of Coverage: \$ \_\_\_\_\_

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**Section 2: Plan Selection for Life Coverage**

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1. Amount of Spouse Life Insurance Desired: \$ \_\_\_\_\_ (\$10,000 to \$100,000 in \$10,000 units)

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**Section 3: Spouse's Statement of Health**

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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

**Section 3: Spouse's Statement of HealthStatement of Health — Continued**

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
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	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
	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

10. In the past 10 years have you ever:  Yes  No

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

d) tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?  Yes  No

11. Within the past 10 years, including the date of this application, have you ever had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application?  Yes  No



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**Section 5: Fraud Notice**

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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.

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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 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.

Member/Employee Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

Spouse 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**