

APPLICATION FOR DISABILITY INSURANCE

PAYMENT MODE			
ANNUAL	<input type="checkbox"/>	CHECK	<input type="checkbox"/>
SEMI ANNUAL	<input type="checkbox"/>	CREDIT CARD	<input type="checkbox"/>

APPLICANT'S NAME			RELATIONSHIP	SEX	DATE OF BIRTH			AGE	HEIGHT	WEIGHT
FIRST NAME	I.	LAST NAME			DAY	MTH	YEAR			
1										
2										
3										
4										
5										
6										
7										
8										

	APPLICANT'S NAME	MONTHLY BENEFIT	PREMIUMS PER PERSON	TOTAL PREMIUMS
1				
2				
3				
4				
5				
6				
7				
8				
	TOTALS:		\$	\$

Permanent Residence (Including City & State)	Mailing Address	Telephone Number
		Fax Number
	Email Address	

Employer's Name and Address	Occupation and Duties	Telephone Number
		Fax Number
	Email Address	

PREMIUMS (A)	\$	ANNUAL PREMIUM	\$
	\$	MODAL FACTOR	X
		PREMIUM DUE	\$

1. HAS ANY PERSON PROPOSED FOR COVERAGE EVER BEEN ADVISED TO OR, RECEIVED MEDICAL CONSULTATION, CARE, TREATMENT OR, TAKEN MEDICATION FOR: (Please circle each condition)		YES	NO	Give full details on "yes" answers of each applicant including diagnosis, dates, duration, names and addresses of all attending physicians and medical facilities.
a.	Heart or circulatory system, chest pain, high blood pressure, angina, shortness of breath, rheumatic fever, cardiac defect, disease of veins or arteries?			
b.	Pulmonary disease, asthma, bronchitis, chronic cough, tuberculosis or allergies?			
c.	Disease or disorder of spleen, pancreas, stomach, intestines, liver, gallbladder, ulcer, colitis, hemorrhoids, colon hepatitis, diverticulitis?			
d.	Kidney disorders, urinary tract diseases, albumin or blood in urine, bladder disorders?			
e.	Musculoskeletal or back disorders, rheumatism, arthritis, gout, lumbago, osteoporosis, deformity, hernia or any skin disorders?			
f.	Cancer, tumors, any blood disorders or leukemia?			
g.	Otitis, septal deviation, nasal trauma?			
h.	Endocrine or thyroid disorders, goiter, diabetes, sugar in urine, swelling of lymphatic nodes?			
i.	Sexually transmitted disease, or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex)?			
j.	Disorders of the menstrual cycle, breasts, ovaries, uterus, fallopian tubes, cervix, vagina, miscarriages, cesarean sections, or others.			
k.	Diseases or disorders of the reproductive system, prostate, testes, pelvic inflammatory disease, endometriosis, or others.			
l.	Convulsions, epilepsy, attacks, paralysis, or any neurological disorders?			
2. HAS ANY PERSON PROPOSED FOR COVERAGE:		YES	NO	
a.	Had health examinations or routine medical check-ups? Any abnormalities?			
b.	Been a patient in a hospital, clinic or sanitarium been recommended to undergo a surgery that is still pending?			
c.	Is anyone currently taking any prescribed medication or under medical treatment or have been advised of the possibility or necessity of future treatment or is currently addicted to drugs or alcohol? Please explain.			
d.	Received treatment for any disorder or condition not mentioned above?			
e.	Is anyone presently covered by another insurance company for either Disability or AD&D?			Company's Name:
f.	Does any person proposed for insurance intend to replace or change an existing policy in connection with this application?			
g.	Ever been disabled for a period of 90 days or more or made a claim on any disability insurance?			Expiration Date: ____/____/____
h.	Currently in good health and free from physical defect or injuries?			

3. Family or personal physician:		4. Students: Full time students, between the ages of 18 and 25 years old.	
Name::		Student's Name:	College/University
Address::			
Phone::	Fax:	<i>Proof of Student status must be submitted</i>	

APPLICANT'S STATEMENT

I hereby certify that all responses and declarations contained in this application are true, complete and correct and I understand and agree that any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the insurer cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or Pre-Existing Conditions, the insurer reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand that the agent receiving this application does not have authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and that all information requested in the application must be set forth in writing on the application. I further understand that this application will become part of the insurance policy to be issued and that the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand that the broker/agent taking this application from me is the representative of and is acting on my behalf and not the administrator nor the insurance company that is offering this insurance. Neither the administrator or the company that is offering this insurance, can be held liable for any circumstance if the broker/agent, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator, to me and/or any documentation or funds from me to the administrator.

It is understood that the insurance applied for shall not become effective until the application is approved and accepted by the insurer, full payment of the first term premium is made and the policy issued subject to all conditions and restrictions contained therein.

I understand that this policy is not available to permanent residents of the United States and Canada or others who reside in the United States and Canada.

APPLICANT'S SIGNATURE _____ **DATED** ____/____/____

MEDICAL AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering this insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering this insurance, and its reinsurers to determine eligibility. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

SIGNATURE OF PROPOSED INSURED _____ **DATED** ____/____/____

SIGNATURE OF APPLICANT'S SPOUSE _____ **DATED** ____/____/____
(If to be insured)

THIS CERTIFICATION AND SIGNATURE FROM THE AGENT "IS NEEDED".

I certify that I have accurately provided all the information given by the applicant and given him/her a copy of the insurance brochure.

AGENT

CODE
EMAIL ADDRESS

AGENT'S SIGNATURE