Professional Insurance Company

Application For Insurance

FRAUD: Any person who, knowingly and with intent to injure, defraud, or deceive any insured files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

❑ **Check if replacing or changing existing coverage in this company. Policy Number** ____________

PERSONS PROPOSED FOR INSURANCE

Last Name First Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.
	Primary Insured	/ /				– –
	Spouse	/ /				
	Child	/ /				COMPLETE SHADED
	Child	/ /				AREAS IF AVAILABLE
	Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Addressee	City	State	Zip	Home Telephone ( )
Payor or Owner if other than Primary Insured	❑ Payor ❑ Owner	Social Security No. – –	Relationship To Primary Insured	
Employer	Date Employed	Occupation		
Hours Worked/Week	Monthly Income $	Group Number	Employee/Payroll Number	
Beneficiary (Estate of Primary Insured unless beneficiary named)			Age	Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? ____Yes ____No. If "No", explain: ____________

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ____Yes ____No. If "Yes", complete replacement form where required.

INSURANCE PLANS

Monthly Premium

DISABILITY Primary Insured Only

	Occ. Class		Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here ______
❑ HPDI2002		Injury	$______	______	______	❑	
❑ ______	❑ 1 ❑ 2	Sickness	$______	______	______		

RIDERS

	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.	______
Primary Ins.	$______	$______	$______	$______	$______	❑	❑	$______
Spouse	$______	$______	$______	$______	$______	❑	❑	$______
Children	$______	$______	$______	$______	$______	❑	❑	$______

$______

HOSPITAL

			Base Policy	RIDERS: AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.
❑ 0/0	180	Primary Ins.	$______	$______	$______	$______	$______	$______	$______
❑ 0/0	365	Spouse	$______	$______	$______	$______	$______	$______	$______
❑ 0/3	365	Children	$______	$______	$______	$______	$______	$______	$______

RIDERS

	Private Nurse	Surgical	Surgical+	Spec. Inj.	1st Hosp. Conf.	______	______
Primary Ins.	$______	$______	$______	❑	❑	$______	$______
Spouse	$______	$______	$______	❑	❑	$______	$______
Children	$______	$______	$______	❑	❑	$______	$______

$______

CANCER

Base Policy $______
❑ Primary Ins.
❑ Family

RIDERS

Surgical	Physician Att.	ICU
$______	$______	$______
Can. ICU	**Chemo**	**Hospice**
$______	$______	$______

❑ Comp. Care
First Occurrence
❑ $500
❑ $1000

Disability Income $500 (Primary Ins. Only)
❑ 6 Month Benefit
❑ 1 Yr Benefit

$______

LUMP SUM CANCER

❑ Individual ❑ 1 Parent ❑ 2 Parent

❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,000

$______

LIFE

Plan:______ Amount$______ ❑ Accidental Death Rider ❑ Waiver of Premium

☐ Opt A ☐ Opt B ______ Units Family Rider ______ Units Children's Rider ❑ Other______

$______

1. **HAS ANY PROPOSED INSURED:** Ever tested positive for exposure to the HIV infection, or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ___ Yes ___ No.

2. **HAS ANY PROPOSED INSURED:** Consulted a Physician, received medical treatment of any kind, or been hospitalized or confined during the past 3 years? ____Yes ____No.

3. **IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? ____Yes ____No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

4. **FOR DISABILITY COVERAGE:** List the amount of any other individual disability insurance currently applied for or in force for the primary insured $________________

5. **FOR CANCER COVERAGE:** Has any proposed Insured ever been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? ____Yes ____No

ADDITIONAL QUESTIONS FOR LIFE COVERAGE:

6. **HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:**
   - **A).** Used marijuana, cocaine, or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? ____Yes ____No
   - **B).** Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? ____Yes ____No
   - **C).** Had or been treated for any disease of the lungs, blood, brain, heart, arteries, kidneys, pancreas, or liver? ____Yes ____No
   - **D).** Had or been treated for Paralysis, cancer, or tumor? ____Yes ____No

7. **HAS ANY PROPOSED INSURED** smoked in the Past 12 months? **Primary Insured** ____Yes ____No **Spouse** ____Yes ____No

Details of "Yes" Answers in 1,2,5 or 6. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Authorization to Obtain and Release Information: I authorize any physician, medical practitioner, hospital, clinic, other medically related facility, insurance or reinsuring company, the Medical Information Bureau, government agency, employer, or consumer reporting agency that has any record or knowledge of me, my employment, or my health or my dependents or their health to give to Professional Insurance Company (PIC), its legal representatives or its reinsurers any such information. Information means facts of a medical nature in regard to my physical or mental condition, employment, other insurance coverage, or any other nonmedical facts. I understand that this information will be used to decide if I am insurable. I authorize PIC to disclose the information to the following: other insurers to which I have applied or may apply; reinsurers, MIB; or those persons who perform business, professional, or insurance tasks for them. They may disclose the information as allowed by law. This authorization will be valid for 30 months from the date signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request and that a copy is as valid as the original.

Insurance Information Practices: Personal information may be collected from persons other than the individual or individuals proposed for coverage. Such information as well as other personal or privileged information subsequently collected by PIC or its agent may in certain circumstances be disclosed to third parties without authorization. You have the right of access and correction of personal information about you except information that relates to a claim or civil or criminal proceeding. You will be furnished upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

WE, the undersigned applicant (Primary Insured) and agent, acknowledge that 1) the applicant has read, or had read to him/her the completed application and agrees that all statements and answers about the applicant and other proposed insureds are complete to the best of the applicant's knowledge and belief and have been truly and accurately recorded; 2) the applicant understands this application shall be part of any policy issued and that any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 3) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 4) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 5) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

Signed at ______________________________ this __________ day of ____________________ 20________
City, State

X ______________________________ X ______________________________ X ______________________________

Signature of Primary Insured (Parent if person to be insured is less than 15 years old) — Payor/Owner (If other than Primary Insured) — Spouse

X ______________________________ ______________________________ ____________ _____ % ____________

Signature of Agent — Agent's Name (printed) — Agent's No. — % Credit — State ID No.

Professional Insurance Company
In California, PIC Life Insurance Company
Mailing Address: P.O. Box 80637, Lincoln, NE 68501-0637 1-800-289-1122

AUTHORIZATION TO HONOR CHECKS DRAWN BY PROFESSIONAL INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Professional Insurance Company, Lincoln Nebraska, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

A VOIDED CHECK MUST BE INCLUDED TO PROCESS YOUR REQUEST

Policies Covered by the Authorization

Policy Number	Premium Amt.	Draft Date	Name of Insured

If a Draft Date is not selected, the Company will use the drafting date occurring on or prior to the policy issue date.

I herby authorize you to charge the account indicated below to pay the amount due on any insurance policy indicated for which I am obligated to pay premium.

Financial Instiution____

City, State, & Zip____

Type of Account (circle one) Checking_____Savings_________Account Number___________________________

Printed Name___________________________________Payor____
Sign Exactly as it appears on records of Financial Institution.

Instructions for Usage and Authorization

To: The Bank Named Above.
So that you may comply with your depositor's request, this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, or order, whether or not genuine, purporting to be executed by this company and received by you in the regular course of business for the purpose of payment (under this plan) including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, draft, or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently to indemnify you for any loss even though dishonor results in a forfeiture of insurance or other right.
3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of payment collection.
4. Authorized in a resolution adopted by the Board of Directors of:

PROFESSIONAL INSURANCE COMPANY