

APPLICATION for
**Group Long-Term
Disability Insurance**



STEP 1: Member Information

Name (First, Middle, Last) _____ Male Female _____ NYSSCPA Member ID No. _____

Email _____ Home Phone (____) _____ Work Phone (____) _____ Age _____ Height _____ Weight _____

Address _____ City _____ State _____ Zip _____

Date of Birth (mm/dd/yyyy) _____ Birth Place (City, State) _____ Name and Address of Member's Physician _____

Are you now, and have you been for the last 90 days, performing all of the duties of your regular occupation for at least 20 hours per week for your present employer? Yes No

Occupation _____ Annual Earned Income (after business expenses) _____ Name and Address of Member's Employer _____

STEP 2: Insurance Requested

Select the Plan and Monthly Benefit of your choice:

Plan 1 (Pays benefits up to age 70)
Choice of Waiting Period: 30 Days 90 Days 180 Days 365 Days
Monthly Benefit Amount (\$100 to \$5,000 in units of \$100): \$ _____
(Not to exceed 60% of your monthly income.)

Plan 2 (Pays benefits for two years)
Waiting Period: 30 Days
Monthly Benefit Amount (\$100 to \$3,200 in units of \$100): \$ _____
(Not to exceed 60% of your monthly income.)

Plan 1

Note: The Monthly Benefit Amount is based upon your Annual Earned Income (after business expenses). Those choosing a 30-day waiting period may only apply for up to \$4,000. Applicants between 60-69 years of age may apply for \$500 per month.

Plan 2

Note: The Monthly Benefit Amount is based upon your Annual Earned Income (after business expenses). Applicants between 60-69 years of age may apply for \$500 per month.

Note: Limited Monthly Benefits will be paid for PRE-EXISTING CONDITIONS (an injury or sickness for which the person incurred charges; received medical treatment, consultation, care, or services, including diagnostic measures; took prescribed drugs or medicines; or had symptoms for which an ordinarily prudent person would have consulted a doctor. Your certificate will contain details regarding the pre-existing condition limitation.

STEP 3: Select Your Payment Mode

I prefer to pay: Automatic Monthly Withdrawal Quarterly Direct Bill Semiannual Direct Bill Annual Direct Bill

Automatic Monthly Withdrawal

By selecting this option, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Remember to include a check for your first month's premium and a blank voided check with your application.**

Bank Name: _____

Bank Address: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days' advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____

Date _____

Group Long-Term Disability Insurance

STEP 4: Please answer these brief questions. To the best of your knowledge and belief:

1. Have you ever had or been treated for (circle specific disorders experienced):	
a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm, or transient ischemic attack?	<input type="radio"/> Yes <input type="radio"/> No
b. Injury, pain, or disorder of neck or back? Sciatica? Any disabling injury or disorder of the bones, joints, or muscles? Connective tissue disorder?	<input type="radio"/> Yes <input type="radio"/> No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	<input type="radio"/> Yes <input type="radio"/> No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?	<input type="radio"/> Yes <input type="radio"/> No
e. Disease or disorder of the rectum? Vascular or blood disorder?	<input type="radio"/> Yes <input type="radio"/> No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?	<input type="radio"/> Yes <input type="radio"/> No
g. Ulcer or disorder of stomach, liver, gall bladder, or pancreas? Colitis, hepatitis, or other disorder of small or large intestine?	<input type="radio"/> Yes <input type="radio"/> No
h. Prostate disorder? Nephritis, nephrosis, or other kidney disease or disorder?	<input type="radio"/> Yes <input type="radio"/> No
i. Menstrual, uterine, or ovarian disorder? Complications of pregnancy? Disorder of the breast?	<input type="radio"/> Yes <input type="radio"/> No
j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders?	<input type="radio"/> Yes <input type="radio"/> No
k. Cancer, tumor, or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?	<input type="radio"/> Yes <input type="radio"/> No
l. Mental or emotional problem requiring help of a physician, psychologist, or counselor?	<input type="radio"/> Yes <input type="radio"/> No
m. A surgical operation? Or a surgical operation advised but not performed?	<input type="radio"/> Yes <input type="radio"/> No
n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system?	<input type="radio"/> Yes <input type="radio"/> No
o. Alcohol or drug abuse?	<input type="radio"/> Yes <input type="radio"/> No
2. Have you, during the past five years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those state above?	
<input type="radio"/> Yes <input type="radio"/> No	
3. Are you now taking prescription medication or receiving medical attention?	
<input type="radio"/> Yes <input type="radio"/> No	

If you answered "Yes" to any part of Questions 1–3 above, please provide details in the spaced provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes." Yes No

Question Number	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals, or Clinics Consulted

STEP 5: Existing and Pending Insurance

<p>1. Do you have any disability insurance in force or pending (including group coverage)?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If "Yes," please indicate companies and amounts:</p> <p>_____</p>	<p>2. Will this coverage applied for replace any insurance now in force?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If "Yes," please indicate which insurance and the amount being replaced:</p> <p>_____</p>
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STEP 6: Please read the following, then sign and date below to apply.

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY: I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

A copy of this application will be attached to and made a part of your certificate.

Signature _____ Date (mm/dd/yy) _____

G-19463-NY