

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**

- Member of Pennsylvania Institute of CPAs** Date of Membership: \_\_\_\_\_ Member #: \_\_\_\_\_
- Employee of a Member of PICPA** Date of Hire: \_\_\_\_\_  
Name and Address of Member/Firm: \_\_\_\_\_
- Employee of PICPA** Date of Hire: \_\_\_\_\_
1. Name: \_\_\_\_\_ 6. Sex:  Male  Female
2. Home Address: \_\_\_\_\_ 7. SSN: \_\_\_\_\_--\_\_\_\_--\_\_\_\_
- City: \_\_\_\_\_ 8. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
- State: \_\_\_\_\_ Zip: \_\_\_\_\_ 9. Place of Birth: \_\_\_\_\_
3. Billing Address: \_\_\_\_\_ 10. Citizenship / Country: \_\_\_\_\_
- City: \_\_\_\_\_ 11. Current Occupation/Profession: \_\_\_\_\_
- State: \_\_\_\_\_ Zip: \_\_\_\_\_ 12. How many hours a week do you work? \_\_\_\_\_
4. Daytime Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ 13. Beneficiary \_\_\_\_\_
5. Email address: \_\_\_\_\_ Relationship of Beneficiary to you: \_\_\_\_\_
14. Application is made for:  New Coverage  Add Optional Benefit(s)  Add Dependent Coverage  Reinstatement  
 Increase: Current Coverage \$\_\_\_\_\_ AD&D \$\_\_\_\_\_ Survivor Benefit \_\_\_ yrs \$\_\_\_\_\_/month

**Section 2: Plan Selection**

*(complete only items being requested. If applying for an increase, only include the additional amount)*

**1. Member/Employee:**

Amount requested: \$ \_\_\_\_\_ (\$20,000 to \$500,000 in increments of \$10,000)  
Optional Benefits: **Accidental Death & Dismemberment** \$ \_\_\_\_\_ (increments of \$10,000, not to exceed life amount)

**Survivor Monthly Income Benefit:**  Plan I (5 years \$500/month)  Plan III (10 years \$500/month)  
 Plan II (5 years \$1000/month)  Plan IV (10 years \$1000/month)

**2. Dependent Spouse**

Name: (Last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_  
Daytime Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
SSN: \_\_\_\_\_--\_\_\_\_--\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship/Country: \_\_\_\_\_

Amount requested: \$ \_\_\_\_\_ (\$20,000 to \$500,000 in increments of \$10,000. Not to exceed member/employees life amount)  
Optional Benefit: **Accidental Death & Dismemberment** \$ \_\_\_\_\_ (increments of \$10,000, not to exceed life amount)

**3. Dependent Children**

Name (if over 21 must be FT student)	Date of Birth	Name (if over 21 must be FT student)	Date of Birth

**Section 3: Other Coverage**

If anyone applying for coverage has Other Life Insurance in force or pending with Unimerica Insurance Company (“Unimerica”) or through any other company, provide details below:

Company Name	Coverage Type	Benefit Amount	Will Coverage be Replaced?	Who is insured?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse

**Section 4: Applicant Statement of Health**

	<u>Member/Employee</u>	<u>Spouse</u>
1. a) Height	__ ft __ in	__ ft __ in
b) Weight	_____ lbs	_____ lbs
c) Weight change last year:	_____ lbs	_____ lbs
d) Reason for weight change (indicate gain / loss and reason)		
2. Name of Personal Physician (If none, please indicate):		
Address		
City, State, Zip		
Phone (include area code)		
Date Last Seen:		
Reason:		
Results:		
	<b>Yes</b> <b>No</b>	<b>Yes</b> <b>No</b>
3. In the past 180 days, have you ever been:		
a) absent from work, or unable to perform any duty of your occupation because of sickness or injury?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
b). been homebound or hospitalized because of sickness or injury?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
If Yes to a) or b), for how many days?		
Date(s):		
Reason:		
4. Has anyone applying for coverage 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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. In the past 10 years, has anyone applying for coverage engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
6. In the past 10 years, has anyone applying for coverage 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"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for Human Immunodeficiency Virus)?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

**Section 4: Applicant Statement of Health (Continued)**

	<u>Member/Employee</u>		<u>Spouse</u>	
	Yes	No	Yes	No
i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) chronic fatigue, Epstein Barr virus, fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Are you pregnant? If "yes", due date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 10 years, has anyone applying for coverage had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 10 years, has anyone applying for coverage 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is anyone applying for coverage 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 10 years, has anyone applying for coverage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. sought, been advised to seek, or received counseling or treatment for the use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 convicted for the possession of or use of prescribed or non-prescribed drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Within the past 10 years, including the date of this application, has anyone applying for coverage 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 5: Medical Details** (Please provide details if you answered YES to any item in the Applicant Statement of Health Section)

Question #	Name of Person for whom you answered "YES"	Reason/Condition	Diagnosis/Treatment/ Results	Name, Address & Phone # of Physician and/or Hospital	Date of Onset	Date Last Seen	# of Days lost from work

**Section 6: Fraud Notice**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

**Section 7: 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.

I hereby authorize Unimerica to give information about me to any organization administering the coverage for which I am applying or as required by law.

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, or that of any member of my family whose name appears in the application to which this is attached, 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 and the producer if applicable also certifies 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:**

**Bollinger, Inc.**  
400 Market Street, Suite 450  
Philadelphia, PA 19106  
Phone: 215-351-4700 • 1-800-952-4050  
Fax: 215-351-9012  
[www.bollingeraffinity.com/PICPA](http://www.bollingeraffinity.com/PICPA)