

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

Membership Affiliation

Member of Pennsylvania Institute of CPAs Date of Membership: _____ Member #: _____

Member Address: _____

City _____ State _____ ZIP _____

Employee of a Member Firm Date of Hire ____/____/____ Member Phone (____) _____ - _____

Member Firm Name _____

New Firm Established Date ____/____/____

- | | |
|--|---|
| 1. Name: _____ | 6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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 Residual Disability Reinstatement
 Increase:
 Current Coverage \$_____/mo. ____Elim. Period ____ Benefit Period Residual Disability Y / N

Section 2: Plan Selection for Disability Income Coverage (If applying for an increase, only include the additional amount):

- MAXIMUM MONTHLY BENEFIT: \$_____ (\$500 to \$10,000 per month if age 18 to 49, \$500 to \$6,000 per month if age 50 to 54, \$500 to \$3,000 per month if age 55 to 59 in increments of \$100, not to exceed 70% of your Monthly Income.
- MAXIMUM BENEFIT PERIOD: (Select one) Lifetime/65 65/65 5/5 5/2
- ELIMINATION PERIOD: (Select one) 0/7 days 30 days 60 days 90 days 180 days 365 days
- OPTIONAL BENEFIT: Residual Disability
- Are you contributing towards the payment of premium for this coverage? Yes No

Section 3: Other Coverage

If You have Disability Income insurance in force or pending with Unimerica Insurance Company (“Unimerica”) or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?		Employer Paid	
					Yes	No	Yes	No

Section 4: Financial Information

1. Employment Type (check one): Non-Owner employee Proprietorship Partnership Corporation S-Corporation
 Limited Liability Partnership Limited Liability Corporation Other (specify): _____
2. Earned income from your occupation
If you are a Non-Owner employee, annual base salary \$ _____ (skip to section 5)
If you are an owner, list your earned income as reportable for Federal Tax purposes (net after business expenses, if any)
Last Calendar Year: \$ _____ Prior Calendar Year: \$ _____
3. Percentage of business owned by you: _____ Number of years owned by you: _____
Number of years business has been in existence: _____

Section 5: Member's / Employee's Statement of Health

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 90 days, 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. During the past 10 years (5 years in IN, KS and MN), have you ever engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? In MN, indicate Yes/No for deep sea diving, parachuting/paragliding, rock/mountain climbing, or organized motorized speed racing Yes No
6. During the past 10 years (5 years in IN, KS and MN) have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details. Except in KS and MN, include conditions for which you have experienced symptoms.
- a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system, blood or blood vessels? Yes No
- b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung? Yes No
- c) diabetes, any glandular, thyroid, or other endocrine disease or disorder? Yes 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? Yes No
- e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease?..... Yes No
- a) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system? (In ME and WI, excluding HIV) Yes No
- g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for HIV)? Yes No
- h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease? Yes No
- i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat?..... Yes No
- j) chronic fatigue, Epstein Barr virus, fibromyalgia? Yes No
- k) complications of pregnancy Yes No
7. Are you pregnant? If "yes", due date: _____ Yes No

Section 5: Member's / Employee's Statement of Health — Continued

8. During the past 10 years (5 years in IN, KS and MN), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME, excluding HIV) Yes No
- A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)
9. During the past 10 years (5 years in IN, KS and MN) have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (In ME, excluding HIV) Yes No
10. During the past 10 years (5 years in IN, KS and MN) 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? (In ME, excluding HIV) Yes No
11. 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 nonprescription) for any reason?..... Yes No
12. During the past 10 years (5 years in IN, KS and MN) have you:
- 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 nonprescribed 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)? (In ME, excluding HIV) Yes No

Section 6: Medical Details (Please provide details if you answered YES to any item in the Member's/Employee's Statement of Health Section):

If you need more space, attach separate sheet with additional information.

Question #	Reason/Condition	Diagnosis/Treatment/Results	Name, Address & Phone No. of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work

Section 7: 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 8: 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 Insurance Company ("Unimerica") grants its underwriting approval. I understand that any condition which is excluded under the Policy will not be covered at any time. I understand that any injury or sickness, including Mental Illness, Substance Abuse or Subjective Symptoms for which: a) I was diagnosed or received Treatment from a Physician or other licensed practitioner of the healing arts, or b) I took any drugs or medications or had symptoms for which an ordinarily prudent person would have sought Treatment; within the 12 month period prior to my effective date of insurance, will not be covered until I have been covered under the Policy for 24 months after my Effective Date.

Although group disability income 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, 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: _____

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.mather-co.com**