

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: _____
2. Home Address: _____
City: _____
State: _____ Zip: _____
3. Billing Address: _____
City: _____
State: _____ Zip: _____
4. Daytime Phone: (____) - ____ - _____
5. Email address: _____
6. Sex: Male Female
7. SSN: _____ -- _____ -- _____
8. Date of Birth: _____ / _____ / _____
9. Place of Birth: _____
10. Citizenship / Country: _____
11. Current Occupation/Profession: _____
12. How many hours a week do you work? _____
13. Your Beneficiary: _____
Relationship of Beneficiary to you: _____
14. Application is made for: **Member** **Employee**

Section 2: Plan Selection:

Amount Requested (\$20,000 to \$100,000, in increments of \$10,000) _____
(New members applying within 90 days eligible up to \$100,000; New employees eligible up to \$50,000)

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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4: Applicant Statement of Health

1. 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"/> Yes <input type="checkbox"/> No
b) been homebound or hospitalized because of sickness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to a) or b), for how many days?	
Date(s):	
Reason:	

Section 5: 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 6: 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: _____

Retain a photocopy of this application for your records and return the original to:



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