

Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828 • Portland, Maine 04112-8828

Disability Income Insurance Application Short Form
Pennsylvania Institute of Certified Public Accountants
Group Policy Number: 2000 Group Number: 900001

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: Employer Information

1. Name of Employer (Member Firm): _____
2. Employer's Phone Number: (____) - ____ - _____

Section 2: Employee Information

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. Beneficiary _____
 Relationship of Beneficiary to you: _____
14. Application is made for: **Increase Monthly Benefit within 90 Days of a Salary Increase** (Detail current coverage in Section 4)
15. In the past 90 days, have you been actively at work on a full-time basis (at least 30 hours / week)? Yes No
 If "No", reason: _____ Date Began Work/Returned to Work: _____

Section 3: Plan Selection for Disability Income Coverage:

1. Additional Maximum Benefit Amount Requested: \$100 \$200 \$300 \$400 \$500
2. Maximum Benefit Period: Same as Your current coverage
3. Elimination Period: Same as Your current coverage as stated in Section 4.
4. Are you contributing towards the payment of premium for this coverage? Yes No

Section 4: 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 5: Financial Information

1. Your Current Monthly Income: _____
2. Date of Your Last Salary Increase: _____

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 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.BollingerAffinity.com/PICPA**