UNITED SECURITY
LIFE AND HEALTH INSURANCE COMPANY

6640 South Cicero Avenue, Bedford Park, IL 60638

Application for Disability Insurance

❑ NEW INSURANCE COVERAGE

❑ ADD-ON

Desired (not guaranteed) Effective Date:

Month _____ Day 1st or 15th

PLEASE TYPE OR PRINT

1. PROPOSED INSURED:

Last First Middle Initial

Residence Address: _____

City: _____ State: _____ ZIP: _____

Birth Date: _____ Age Last Birthday: _____

Birthplace: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married

Height: Ft. _____ In. _____ Weight: _____ lbs.

Social Security No.: _____

Home Phone No: (_____) _____

Beneficiary (Full Name): _____

Relationship: _____

2. COMPLETE THE FOLLOWING BUSINESS INFORMATION:

Name of Employer: _____

Employer's Address: _____

City, State, ZIP: _____

Business Phone: (_____) _____

Occupation Title: _____

Duties (describe in detail): _____

Basic Earnings: $ _____ ☐ Wk. ☐ Mo. ☐ Yr.

(If Self-Employed, list income **after business expenses paid** as reported on most recent IRS Form 1040.)

Other Occupations in Last Five Years: _____

3. SELECT THE FOLLOWING OPTIONS: (Higher Amounts Available with Underwriting Approval)

Monthly Benefit: $ _____ ($400 - $3000) Maximum 2/3 of Monthly Salary

Benefit Period: ☐ 6 Mos. ☐ 1 Year ☐ 2 Years ☐ 5 Years (Only Available to P Class)

Elimination Period: ☐ 7 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Payment Method: ☐ Annual ☐ Semi-Ann. ☐ Qrtly. ☐ Monthly ☐ PAC

Credit Card Visa/Master Card/Discover: _____

Expiration Date: _____

4. A. What Disability Income Plans do you now have, and what applications do you now have pending for other plans?

Name: _____

Amount of Monthly Benefit: $ _____

B. Will this Policy replace any current coverage? ☐ **Yes** ☐ **No**

5. Have you:

A. Missed any work days due to health reasons in the last 6 months? ☐ **Yes** ☐ **No**

B. Made a claim for, or received benefits from, any source for disability? ☐ **Yes** ☐ **No**

	Yes	**No**
6. Do you contemplate, or have you within the last two years, been engaged in the following activities: Hang Gliding, Parachuting, Parasailing, Racing (any kind), riding a Motorcycle, ATV, or Dirt Bike, Rodeo Activities, Mountain Climbing, Competitive Skiing, Scuba or Sky Diving, or other hazardous sports or hobbies?	☐	☐

7. A. Driver's License No.: _____

State: _____

8. Have you ever had your driver's license suspended or revoked, been cited for driving while intoxicated in the past 5 years, or had two or more violations in the past two years?	☐	☐

If YES, Explain: _____

9. Have you smoked cigarettes, cigars or a pipe, or chewed tobacco within the last year?	☐	☐
10. Have you had any diagnosis related to, received treatment for, been advised to seek treatment, or been hospitalized due to alcohol or drug use/abuse?	☐	☐
11. In the past five years, have you taken any prescription medication or received any medical treatment?	☐	☐
12. *Have you ever been diagnosed or treated for:		
A. Heart Trouble or Circulatory System Disorders?	☐	☐
B. High Blood Pressure?	☐	☐
C. Abnormal Pulse?	☐	☐
D. Lung or Respiratory Trouble?	☐	☐
E. Stomach or Intestinal Trouble?	☐	☐
F. Disorder of the Bladder, Kidney or Urinary System?	☐	☐
G. Spine or Back Disorder?	☐	☐
H. Disease or Disorder of Muscle, Bones or Joints?	☐	☐
I. Arthritis or Rheumatism?	☐	☐
J. Neuritis or Sciatica?	☐	☐
K. Nervous or Mental Disorder?	☐	☐
L. Diabetes or Sugar in Urine?	☐	☐
M. Cancer, Tumors or Leukemia?	☐	☐
N. Liver or Gall Bladder Trouble?	☐	☐
O. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
P. Disease or Disorder of the Immune System?	☐	☐
Q. Sickle Cell Anemia or Blood Disorder?	☐	☐
13. Have you within the past 5 years:		
A. Experienced a Persistent Cough, Chronic Fatigue, Significant Weight Loss, Night Sweats, Enlarged Glands or Chronic Diarrhea?	☐	☐
B. Been advised to have a surgical operation?	☐	☐
C. Been a patient or advised to enter a hospital or health care facility?	☐	☐
D. Consulted, been attended or examined by a doctor or other practitioner?	☐	☐
14. Have you any physical deformities, impairment or ill health not recorded in answer to questions 9, 10, 11, 12 and 13?	☐	☐

* Indiana residents need only relate their history for past 5 years.

Save...Time and Money

Pre-authorized Checking (PAC) Plan or Electronic Transfer are the convenient ways to pay your premiums. Payments are always on time with no unintentional lapses of your valuable protection. You have no checks to make out, no postage stamps to bother with, no premium notices to return, and less cost in billing fees.

If PAC or Electronic Transfer ATTACH VOIDED CHECK HERE and complete Authorization.

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED SECURITY LIFE AND HEALTH INSURANCE COMPANY

Bank Name _____ Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge my account (checks or electronic debits) drawn on my account by and payable to United Security Life and Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Printed Name of Depositor _____ Signature of Depositor _____

Date _____

Provide details to Questions 5 through 14 which have been answered "YES".

Question Number	Illness, Injury or Other	Date	Details, Length of Disability, Degree of Recovery	Complete Name of Physician, Hospital, or Clinic and Current Address

To provide additional medical history, use a separate sheet of paper.

INSURED'S STATEMENT AND HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby apply to United Security Life and Health Insurance Company for insurance. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, United Security Life and Health Insurance Company's only obligation will be to return any premium paid; and, (c) that United Security Life and Health Insurance Company will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from United Security Life and Health Insurance Company and the initial premium, including the applicable fee, is paid in full.

By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medical or medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give United Security Life and Health Insurance Company, its reinsurers, affiliates, or business associates, any such information which shall include, but not be limited to, Alcohol or Drug abuse treatment, Mental Health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing. I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. I acknowledge receipt of the important notice regarding a consumer report and disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to United Security Life and Health Insurance Company, P.O. BOX 388342, Chicago, Illinois 60638, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or the extent that United Security Life and Health Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original.

Upon request I, or my authorized representative, is entitled to receive a copy of this authorization form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Disclaimer – If premiums are paid from your employer's account, it is understood that:

1. United Security Life and Health Insurance Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor, will be fulfilled by the employer, as his own legal counsel may determine.

2. The policy is not guaranteed issue and will be fully underwritten by the Company which may result in the exclusion from coverage of certain family members (if applicable) and health conditions. United Security Life and Health Insurance Company assumes no responsibility for collection of premiums and/or failure of your employer to remit them on a timely basis.

Dated at _____ _____ 20_____
City State Date

Applicant's Signature _____

AGENT INFORMATION

I have truly and accurately recorded the information personally supplied by the applicant.
I made no representations to the applicant other than those contained in the sales brochure.

Producer's Signature _____

Agent # _____ Agent's E-mail _____

Agent's Name (Printed) _____

Address _____

City _____ State _____ Zip _____

Phone Number: (_____) _____

General Agent: _____

DI-06APP

RATE CALCULATION TABLE

Benefit Period:
_____6 months
_____12 months
_____24 months
_____60 months

Elimination Period:
_____7 days
_____14 days
_____30 days
_____60 days (5 Year Plan Only)
_____90 days (5 Year Plan Only)

Occupational Classification: _____P _____A _____B

Current Age: _____ (Must be 18 – 59 years of age.)

Monthly Benefit: $___ $400.00 to $3000.00 (4 – 30)

Calculation:

Rate (per $100)	$_____
Monthly Benefit	x _____
Premium	$_____
Billing Fee	+$_____
Total Payment	$_____

ABBREVIATED NOTICE OF INFORMATION PRACTICES – As permitted by law, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that: 1.) Personal information may be collected from persons other than the individual or individuals proposed for coverage, 2.) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization, 3.) You have the right to access the information and correct it, 4.) Your right of access does not include any information which relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding, 5.) A more detailed notice of Insurance Information Practices will be furnished to the applicant or policyholder upon request.

FAIR CREDIT REPORTING ACT NOTICE – If an investigation is conducted in connection with your application, you are entitled, under Federal Fair Credit Reporting Act, to disclose of the nature and scope of that investigation. If a consumer investigative report is prepared, you may obtain a copy of such report. You may request to be interviewed for the preparation of the Investigative Consumer Report. Further information regarding the investigation and any investigative consumer reports may be obtained by mailing your request to the office identified at the end of the notice. The type of information we may obtain includes any which relates to your mental and physical health, character and general reputation, habits, finances, occupation, income, insurance coverage, participation in aviation and other hazardous activities. If insurance is sought for members of your family, similar information may be requested about them. We may also obtain information from your friends, neighbors, associates, and past and present employers, either directly or through an investigative consumer report. Information obtained by an insurance-support organization may be retained by it and disclosed to other persons as permitted by the Federal Fair Credit Reporting Act and other applicable laws.

MEDICAL INFORMATION BUREAU PRE-NOTICE – We or our reinsurers may make a brief report regarding your insurability to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, or submit a claim for benefits to a Bureau member company, the Bureau, upon request, will supply such company with the information it may have on its file. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. Upon receipt of request from you, the Bureau will arrange disclosure to you of any information it may have in your file. (Medical information will be disclosed to your attending physician.) If you question the accuracy of the information contained in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02110; telephone number (617) 426-3660.

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LEAVE WITH APPLICANT

HEALTH CONDITIONAL RECEIPT

Applicant Proposed Insured

Plan Applied For

Amount Received Requested Effective Date Date of Receipt

Bottom of page two application

No coverage will become effective prior to delivery of the policy applied for unless and until all conditions of this receipt are met. No agent has the authority to alter the terms or conditions of this receipt;

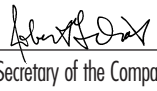
IF (1) an amount equal to the first full premium is submitted; and

(2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and

(3) the proposed insured is insurable for insurance exactly as applied for without modification or plan, premium rate, or amount according to the Company's rules and practices.

THEN insurance under terms of the policy applied for in the same manner and subject to the same rights, conditions and defenses as if the policy applied for had been issued and delivered shall become effective on (a) the 1st or 15th of the month next following the date of application or (b) the date of issue requested in the application, subject to underwriting approval and in accordance with the Company's rules and practices.

IF, FOR ANY REASON, THE COMPANY DECLINES TO ISSUE A POLICY, OR OFFERS TO ISSUE A POLICY OTHER THAN AS APPLIED FOR, THE COMPANY SHALL INCUR NO LIABILITY UNDER THIS RECEIPT EXCEPT TO RETURN ANY AMOUNT RECEIVED.



Secretary of the Company Signature of Agent