Disability Insurance Application

PART I

Please complete the following. I (we) hereby apply for a new policy of insurance conforming to the specifications below.

SPECIFICATIONS

1a. Name *(First, M.I., Last)*

b. Proposed Insured's SS# ___ ___ ___-___ ___-___ ___ ___ ___

c. Sex ☐ M ☐ F

d. Date of Birth *(Mo., Day, Yr.)*

e. Age nearest Birthday

f. Place of Birth *(State)*

2a. Residence *(No., Street, City, State & Zip Code)*

b. Phone Numbers *(Work)* *(Home)*

3a. Regular Occupation

b. How long so employed?

c. Are you currently engaged in your regular occupation on a full time basis without any medical restrictions? ☐ Yes ☐ No
If "No," please provide details.

d. List and describe all duties of your regular occupation and any other occupation

e. Name of employer and nature of business

f. Place of Business *(No., Street, City, State & Zip Code)*

4a. Loss Payee *(Recipient of benefits)* AND relationship to Proposed Insured.

b. Loss Payee's Tax I.D. # or Soc. Sec. # ___ ___ ___ ___ ___ ___ ___ ___ ___

5a. Owner AND relationship to Proposed Insured

b. If Owner is other than the Insured, Owner's SS# ___ ___ ___-___ ___-___ ___ ___ ___ or Tax I.D. # ___ ___-___ ___ ___ ___ ___ ___ ___

c. If Owner is other than an individual, indicate whether a

☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Subchapter S Corporation

6a. To whom shall premium notices be sent? ☐ To both Insured and Owner ☐ To Owner only ☐ To Insured only **(Owner must sign Application)**

b. If Insured is to receive premium notices, where should they be sent? ☐ Insured's residence ☐ Other ☐ Insured's business

c. If Owner is to receive premium notice, where should they be sent? Street and No. City State Zip Code

7. **AMOUNT REQUESTED**	Monthly Benefit	Elimination Period	Benefit Period
Temporary Total Disability (TTD)			
	Lump Sum Benefit	Waiting Period	Benefit Period
Permanent Total Disability (PTD)			Not Applicable

8a. Do you have any other disability insurance currently in force? ☐ Yes ☐ No
If "Yes," complete the information below.

b. Do you intend to cancel any of the below insurance coverages at, or prior to their next premium due dates? ☐ Yes ☐ No

Company Name	Type of Coverage	Policy Number	Monthly Amount	Next Premium Due Date	Is Premium Paid by Employee?

9a. What percentage, if any, of the total premium is being paid by the employer? ________%

b. What percentage, if any, of the employer paid premium will be included as taxable income to the proposed Insured? ________%

10. List all existing disability coverage such as Individual Disability, Accident and/or Sickness, Group LTD, Salary Continuation Plans, Association Insurance and Disability Buy-out. *If "none," so state.*

Company Name	Type of Coverage	Benefit Period	Premium Paid by Employer		Total Benefit Amount			SISB Amount (if any)
			Yes	No	Amount	Monthly	Lump (DBO)	
						☐	☐	
						☐	☐	
						☐	☐	

11. Are you negotiating for other Disability or Life Insurance? ☐ Yes ☐ No *If "Yes," give details below.*

Company Name	Type of Coverage	Face or Monthly Amount	Disability Benefit Period

12. Are you eligible for State Disability Benefits? ☐ Yes ☐ No Workers' Compensation ☐ Yes ☐ No Social Security ☐ Yes ☐ No

13. S PORTING ACTIVITIES

14. OTHER ACTIVITIES AND HOBBIES

15. Amount of payment submitted with this application? $

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree a) that this Disability Insurance Application (pages 1 and 2) shall form a part of any policy issued, and b) that no Agent/Representative of the Company shall have the authority to waive a complete answer to any question in this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements.

Changes or corrections made by the Company and noted in Item 15 above are ratified by the Owner upon acceptance of a contract containing this Application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation, amendments as to plan, amount, age at issue, classification, or benefits will be made only with the Owner's written consent.

Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for Insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, as determined by a court of competent jurisdiction.

Dated: Month, Day & Year

I hereby certify that I have truly and accurately recorded all of the information supplied by the Applicant
Witness - Licensed Representative

Signature of Proposed Insured

TAX CERTIFICATION FOR EMPLOYER PURCHASED INSURANCE ONLY

Certification - Under penalties of perjury, I, Owner of the policy applied for, certify that:
(1) The number shown below is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**
(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instruction - You must cross out item (2) if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by IRS that you were subject to backup withholding you received another notification from IRS that you are no longer subject to backup withholding, do not cross out item (2).

Taxpayer Identification Number (of Proposed Insured or Owner if other than Proposed Insured)	Backup Withholding on Accounts Opened After 12/31/83
Enter the identification number in the appropriate box. For most individual taxpayers, this is the social security number. Social Security Number ______ OR Employer Identification Number ______	Check the box if you are NOT subject to backup withholding under the provisions of section 3406(a) (1)(C) of the Internal Revenue Code........... ☐

Certification - Under the penalties of perjury, I certify that the information provided on this Required Taxpayer Identification Number form is true, correct and complete.

Signed on ______________________, ______ ______________________
Month Day Year Signature of Owner

CERTIFICATION BY REPRESENTATIVE

The Licensed Representative who witnessed the signature(s) on this Application certifies that:
1) He/she asked all the questions on this application, and recommends this risk to the Company without reservation.
2) The policy being applied for
☐ is not intended to replace existing Disability Insurance ☐ is intended to replace existing Disability Insurance

Licensed Representative	Signature		
Pro Financial Services	Signature	**Rep #**	**Share %**
Licensed Representative	Name	Representative Code	Share %
Second Licensed Rep.	Name	Representative Code	Share %
Third Licensed Rep.	Name	Representative Code	Share %
Fourth Licensed Rep.	Name	Representative Code	Share %

SECTION FOR HOME OFFICE ADMINISTRATION STAFF

1. Verify that the licensed Representative who signed the application is licensed in the state in which the application was taken.
2. Answer the following with respect to the Licensed Representative.
   a. Broker Agreement is: ☐ in force ☐ pending ☐ not required
   b. Agreement - what type? ______________________
3. Office to which contract is to be sent ______________________ 4. Office Code ______________________