

Return this completed form to:
Insurance Specialists, Inc.
P.O. Box 2327
Beaufort, SC 29901

Control #50006

Please print all answers using black ink.

Phone: 800-241-7753 • Fax: 866-871-2170 • E-mail: sales@isi1959.com

1 Member Information

Name of Association _____

First Name MI Last Name

Street Apt.

City State ZIP Code -

Date of Birth (mm/dd/yyyy) Social Security Number - - Daytime Telephone Number - -

Sex Male Female Height ft. in. Weight lbs. Evening Telephone Number - -

Annual Earned Income \$ _____

2 Coverage Amounts

Choose the type of coverage and amounts for which you are applying.

Choose a monthly coverage amount in increments of \$100 (\$500 minimum) up to the maximum monthly coverage amount you are eligible for (under age 55: \$10,000; ages 55-59: \$7,500). Remember, your monthly coverage amount, plus any other disability income coverage you may have, cannot exceed 70% of your gross earned monthly income.

Member's Monthly Coverage Amount: \$ _____

Elimination Period (select one): 30 days 60 days 90 days 180 days

Benefit Duration (select one): to age 65 5 years 2 years

Optional Coverages: Cost of Living Adjustment
 \$10,000 Critical Illness Lump Sum Benefit

Other Coverage—Do you now have or are you now applying for other disability insurance which provides benefits if you are unable to work because of disability? Yes* No

**If you answered "Yes" please provide full details below. (If more space is needed, please attach an additional sheet.)*

Company	Plan	Monthly Benefit	Benefit Period

3 Health Questions

Please answer these questions by checking "Yes" or "No."

Yes No

1. Are you currently performing all the duties of your job on a full-time basis (a minimum of 20 hours per week)? If no, please explain: _____

2. Within the last five years, have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:

- a.** Disease or disorder of the heart, blood or circulatory system
- b.** High blood pressure
- c.** Cancer or tumors
- d.** Lung, respiratory or breathing disorders
- e.** Diabetes
- f.** Liver or kidney disorders
- g.** Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones
- h.** Mental or nervous illness or disorder, alcoholism or drug addiction
- i.** Chronic pain or fatigue syndrome
- j.** Neurological disorders such as Multiple Sclerosis or Parkinson's Disease
- k.** Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome
- l.** HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

3

Health Questions

continued from page 1

- 3. Within the last five years**, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
- 4. Within the last five years**, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
- 5. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?
- 6. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

If you answered "Yes" to any of questions 2-6, please provide full details below.

(If more space is needed, please attach an additional sheet.)

Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Care Physician Information

Name Date last seen Telephone

Address

4

Contribution Payment Basis

I request the following payment basis (please check one):

- Annual
- Semi-Annual
- Monthly Electronic Fund Transfer (EFT)*

** If electing EFT, you must complete the Electronic Fund Transfer Authorization section below*

5

Electronic Fund Transfer Authorization

If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your savings account, you must confirm that your bank permits electronic fund withdrawals from savings accounts. By my signature below I authorize the administrator in accordance with the Agreement (included on page 4 of this Form) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

Type of Account: Checking Savings

Account Owner's Name Bank Name

Bank's Transit Routing Number (if savings account only) Your Savings Account Number

X
Signature of Account Owner

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded.) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. 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. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my knowledge and belief. I understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I also understand that coverage will not take effect if the facts have changed. I have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

New York Residents: 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident and disability income coverage. **Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Date (mm/dd/yyyy)

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X

Member Signature

Important Notice: For residents of all states except District of Columbia, Florida, Kentucky, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington:

Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information, materially related to a claim, was provided by the applicant. **Kentucky Residents:** 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 commits a fraudulent insurance act, which is a crime. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Pennsylvania and Utah Residents:** 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 and subjects such person to criminal and civil penalties.

Vermont Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law. **Virginia Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Electronic Fund Transfer Authorization: Insurance Specialists, Inc. Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the tenth of each month that the payment is due. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution charge. You will be notified in advance of changes to the amount of your debit due to premium contribution charges.

Please keep this notice for your records.