

FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Check if replacing or changing existing coverage in this company. Policy Number \_\_\_\_\_

**PERSONS PROPOSED FOR INSURANCE**

Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.
			Primary Insured	/ /				- -
			Spouse	/ /				
			Child	/ /				
			Child	/ /				
			Child	/ /				
Address			City	State	Zip	Home Telephone ( )		
Secondary Addressee			City	State	Zip	Home Telephone ( )		
Employer			Date Employed		Hours Worked/Wk			
Occupation		Monthly Income \$	Group Number		Employee/Payroll Number			
Payor or Owner if other than Primary Insured			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security No. - -		Relationship To Primary Insured		
Beneficiary						Age	Relationship	

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? Yes \_\_\_ No \_\_\_ If "No", explain: \_\_\_\_\_

USED TOBACCO in the past 12 months? Primary Insured \_\_\_ Yes \_\_\_ No Spouse \_\_\_ Yes \_\_\_ No

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? Yes \_\_\_ No \_\_\_ If "Yes", complete replacement form where required.

**INSURANCE PLANS**

DISABILITY Primary Insured Only								Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here	Monthly Premium
<input type="checkbox"/> HPDI2002	Occ. Class	Injury	\$ _____										
<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2	Sickness	\$ _____										
<b>RIDERS</b>	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.						
Primary Ins.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					
Spouse	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					
Children	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					\$ _____
<b>HOSPITAL</b>		Base Policy	AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.					
<input type="checkbox"/> 0/0	180 Primary Ins.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____					
<input type="checkbox"/> 0/0	365 Spouse	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____					
<input type="checkbox"/> 0/3	365 Children	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____					
<b>RIDERS</b>	Private Nurse	Surgical+	Spec. Inj.	1st Hosp. Conf.									
Primary Ins.	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____							
Spouse	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____							
Children	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____							\$ _____
<b>CANCER</b>		Surgical	Physician Att.	ICU	<input type="checkbox"/> Comp. Care	Disability Income \$500 (Primary Ins. Only)							
Base Policy	\$ _____	\$ _____	\$ _____	\$ _____	First Occurrence								
<input type="checkbox"/> Primary Ins.	<b>RIDERS</b>	Can. ICU	Chemo	Hospice	<input type="checkbox"/> \$500	<input type="checkbox"/> 6 Month Benefit							
<input type="checkbox"/> Family		\$ _____	\$ _____	\$ _____	<input type="checkbox"/> \$1000	<input type="checkbox"/> 1 Yr Benefit							\$ _____
<b>LUMP SUM CANCER</b>		<input type="checkbox"/> Individual	<input type="checkbox"/> 1 Parent	<input type="checkbox"/> 2 Parent									
		<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000							\$ _____
<b>LIFE</b>	<input type="checkbox"/> LPRT2002	Amount \$ _____	<input type="checkbox"/> Accidental Death Rider	<input type="checkbox"/> Waiver of Premium									
	<input type="checkbox"/> _____	Units Family Rider	Units Children's Rider	<input type="checkbox"/> Other _____									\$ _____

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE**

**1. HAS ANY PROPOSED INSURED:**

- A) Ever been treated for or diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or ARC (AIDS Related Complex)?  Yes  No.
  - B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years?  Yes  No.
  - C) In the past 2 years had a driver's license suspended/revoked?  Yes (License # \_\_\_\_\_ State \_\_\_\_\_)  No.
- 2. IS ANY PROPOSED INSURED** currently covered or eligible for Medicare?  Yes  No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.
- 3. Are you currently covered by an individual or group health policy or contract that provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans (i.e., a comprehensive, major medical plan)?**  Yes  No. If you have answered NO to the above question, we cannot, by California Law, offer you our specified disease or hospital confinement idemnity coverage at this time.

**D1. FOR DISABILITY COVERAGE:** List the amount of any other individual disability insurance currently applied for or in force for the primary insured \$ \_\_\_\_\_

**C1. FOR CANCER COVERAGE:** Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever?  Yes  No

**L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:**

- A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use?  Yes  No
- B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified?  Yes  No
- C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor?  Yes  No

**Details of "Yes" Answers in 1, D1, C1 or L1.** Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

**Insurance Information Practices:** This notice describes the practices we, PIC Life Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

**Agreement:** I have read, or had read to me the completed application and agree that 1) all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses Incontestability Provision and Legal Proceedings under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8) no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

**Home Office Corrections and/or Additions Only**

X \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/20\_\_\_\_  
**Signature of Primary Insured** City, State Date  
 (Parent if person to be insured is less than 15 years old)

X \_\_\_\_\_ X \_\_\_\_\_  
**Signature of Owner** (If other than Primary Insured) **Spouse**

**AGENT'S STATEMENT:** I, the undersigned agent, also certify that to the best of my knowledge, replacement  is  is not involved at this time.

X \_\_\_\_\_ / \_\_\_\_/20\_\_\_\_ %  
 Signature of Agent Date Agent's No. % Credit State ID No.

**ELECTION FORM**  
**Professional Insurance Company**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

On the accompanying benefit applications and this enrollment form, I have applied for certain benefits offered through the above group. It is my decision to receive the following through allotment/payroll deduction.

DISABILITY PLAN - OCCII - 14/14 - 1 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	\$300	\$7.10
	\$400	\$9.46
	\$500	\$11.83
	\$600	\$14.19
	\$800	\$18.92
	\$900	\$21.29
	\$1,000	\$23.65
	\$1,200	\$28.39
	\$1,300	\$30.75
	\$1,400	\$33.12
	\$1,500	\$35.48
	\$1,600	\$37.85
	\$1,700	\$40.21
	\$1,800	\$42.58
	\$1,900	\$44.94
	\$2,000	\$47.31

DISABILITY PLAN - OCCII - 14/14 - 2 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	\$300	\$8.37
	\$400	\$11.16
	\$500	\$13.95
	\$600	\$16.74
	\$800	\$22.32
	\$900	\$25.11
	\$1,000	\$27.90
	\$1,200	\$33.49
	\$1,300	\$36.28
	\$1,400	\$39.07
	\$1,500	\$41.86
	\$1,600	\$44.65
	\$1,700	\$47.44
	\$1,800	\$50.23
	\$1,900	\$53.02
	\$2,000	\$55.81

**OPTIONAL RIDERS AVAILABLE**

	Employee only	\$4.13
	Employee/Spouse	\$7.80

	Employee/Children	\$8.54
	Employee Family	\$12.21

Total Bi-Weekly: \$ \_\_\_\_\_ Add \$2.00 Fee = Total Allotment: \$ \_\_\_\_\_  
 (includes any Rider Costs)

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**BANK AUTHORIZATION PLAN:** It's the mistake-proof method of paying your premiums -- as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no paper work for you and no more checks to write. It's easy, reliable, and automatic so that your valuable coverage will not lapse.

Authorization Agreement for [name] \_\_\_\_\_ Type of Account:      Savings[ ]      Checking[ ]  
Routing # \_\_\_\_\_  
Account #: \_\_\_\_\_  
⇒⇒(PLEASE ATTACH ONE BANK VOIDED CHECK)

I (we) hereby authorize Benefitis Unlimited Inc. to initiate debit entries to my (our) checking account indicated below, and the bank or credit union named below, herein called BANK, to debit the same to such account. This authorization is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and manner as to afford BANK a reasonable opportunity to act on it. This authorization includes authority for increases in the program for as long as I remain a member in the program. A customer has the right to have the amount of an *erroneous* debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after charge, whichever comes first.

Bank Name: \_\_\_\_\_ Bank Address: \_\_\_\_\_  
Bank City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone # \_\_\_\_\_  
Print Your Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Signature ⇒ \_\_\_\_\_ date: \_\_\_\_\_