PIC Life Insurance Company

Application For Insurance

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 ❑ Payor ❑ 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

Monthly Premium

DISABILITY Primary Insured Only

	Occ. Class		Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here
❑ HPDI2002		Injury	$____	____	____	❑	____
❑ ____	❑ 1 ❑ 2	Sickness	$____	____	____		

RIDERS

	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.	____
Primary Ins.	$____	$____	$____	$____	$____	❑	❑	$____
Spouse	$____	$____	$____	$____	$____	❑	❑	$____
Children	$____	$____	$____	$____	$____	❑	❑	$____

Monthly Premium: $____

HOSPITAL

		Base Policy	RIDERS: AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.
❑ 0/0 180	Primary Ins.	$____	$____	$____	$____	$____	$____	$____
❑ 0/0 365	Spouse	$____	$____	$____	$____	$____	$____	$____
❑ 0/3 365	Children	$____	$____	$____	$____	$____	$____	$____

RIDERS

	Private Nurse	Surgical+	Spec. Inj.	1st Hosp. Conf.	____	____
Primary Ins.	$____	$____	❑	❑	$____	$____
Spouse	$____	$____	❑	❑	$____	$____
Children	$____	$____	❑	❑	$____	$____

Monthly Premium: $____

CANCER

Base Policy $____
❑ Primary Ins.
❑ Family

RIDERS

Surgical	Physician Att.	ICU	❑ Comp. Care	Disability Income $500 (Primary Ins. Only)
$____	$____	$____	First Occurrence	
Can. ICU	Chemo	Hospice	❑ $500	❑ 6 Month Benefit
$____	$____	$____	❑ $1000	❑ 1 Yr Benefit

Monthly Premium: $____

LUMP SUM CANCER ❑ Individual ❑ 1 Parent ❑ 2 Parent

❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,000

Monthly Premium: $____

LIFE ❑ LPRT2002 Amount $____ ❑ Accidental Death Rider ❑ Waiver of Premium

❑ ____ ____ Units Family Rider ____ Units Children's Rider ❑ Other____

Monthly Premium: $____

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 (Parent if person to be insured is less than 15 years old) — City, State — Date

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:_______________

Privacy Act: The collection of this information is authorized by 39 USC 401, 1003 and 5 USC 8339. This information is used to transfer your salary or portion thereof, to financial organizations for credit to your designated account. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain informaiton relevant to a USPS decision concerning employment, security clearances, contacts, licenses, grants, permits, or other benefits; to a government agency at your request when relevant to its decisionconcerning employment, security clearances, security or suitable investigations, contracts, licenses, grants, permits or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fullfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review or private relief legistlation; to an independent certified public accountant during an official audit of USPS finiances; to an investigator, adminstrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEo complaint under 29 CFR 1613; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to the Office of Personnel Management, Social Security Adminstration, Veterans Adminstration, Office of Workers' Compensation Programs, health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employees/annuitant data systems used to analyze Federal Ritrement and insurance costs. Completion of this form is voluntary; however, if this information is not provided, your desires may not be met.

Part I - (Initiated by Employee)

1. **Employee Name** *(As Shown on Check)*

2. Social Security Number

3. **Home Address** *(No. and Street, Apt, City, State, Zip+4)*

4a. Where Employed *(City, State, Zip+4)*

Employee Express Login ID

Employee Express Password

4b. Finance Number

Complete Applicable Item(s) Below

5a. Administration Section

5b. ESTABLISH an ALLOTMENT in the Amount of: $

5c. CHANGE My PRESENT ALLOTMENT FROM: $ TO: $

5d. CANCEL my ALLOTMENT in the Amount of:

5e. Check (✔)This Item if You Have More Than One Allotmentto a Financial Organization ☐

I certify that I am entitled to the payment identfied above, and that I have read and understand the information printed above. In signing this form, I authorize my payment to be sent to the financial organization named below to be deposited to the designated account.

6a. Employee (Signature)
X

6b. Date Signed

6b. Effective Date[1] ASAP

Part II - (Completed by Financial Organization, Return Original and Copy to Employee)

Financial Organization Certification

I confirm the identity of the above signed named payee(s) and the account number in title. As representative of the below named financial organization, I certify that the financial organization agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210. Pursuant to Treasury Department regulations, multiple deposits will not be made to a single common account, except for those accounts (such as husband and wife) in which employees name(s) appear in the title.

7a. Financial Organization (Name, No. and Street, City, State, ZIP + 4)

CHASE MANHATTAN BANK, N.A.
1 CHASE MANHATTAN PLAZA
NEW YORK, N.Y. 10081

7b. Financial Organization Routing Number: 0 2 1 0 0 0 0 2

Check Digit[2]: 1

7c. Employee's Account Number to Be Credited (Up to 17 positions): B U I

7d. Type of Account

☒ Savings ☐ Checking

Authorized By

8a. Name (Print or Type)
ALLEN J. RUSKIN

8a. Title
VICE PRESIDENT

8c. Signature

8d. Date Signed
JAN 1, 2005

1 Request must be received at DDE site no later than Wednesday of the week in which the pay period ends in order to be effective for a particular pay period. Later receipts will be processed the following pay period.
2 Financial organizations must furnish their routing transit number (the number assigned by Rand McNally). This is an eight digit number plus a single digit. It is IMPORTANT that this number be accurate, as disbursements will be made according to this routing number

NOTE: The Employee must return in the original to the Personnel Office for processing.