❑ New Application ❑ Group No. _____ ❑ Change/Policy No. _____

APPLICATION FOR GROUP DISABILITY INSURANCE

Central United Life Insurance Company

10700 Northwest Freeway, Houston, Texas 77092 Toll Free Telephone: 1-800-669-9030

Proposed Insured (First / Middle / Last)	Sex F	Birthdate / /	Age	Ht.	Wt.	Social Security Number - -

Home Address _____ (No. / Street / City / State / Zip) Home Phone # ( ) _____

Employer Name _____ Phone # ( ) _____

Occupation _____ Annual Salary $ _____ Date of Employment ___/___/___

Disability Income Coverage Data

Elimination Period	Plan Code	Benefit Amount	Total Premium
❑ 0/7 ❑ 7/7 ❑ 14/14 ❑ 30/30			
Benefit Period (Months)	**Optional Coverages**		
❑ 3 ❑ 6 ❑ 12 ❑ 24	❑ Survivor Rider		
	❑ Other _____		
		Total	

Premium Mode:
❑ Monthly
❑ Other _____

Requested Effective Date
_____

PART A

	Yes	No
1. Is the coverage applied for intended to replace or be in addition to any disability coverage you now have? (if yes, give company name) _____	❑	❑
2. Will the total monthly amount of disability insurance under all coverage on proposed insured exceed 65% of your monthly earnings?	❑	❑
3. Are you currently, actively at work on a full-time basis and able to perform the duties of your occupation?	❑	❑
4. Are you a legal resident of the USA?	❑	❑

BENEFICIARY

First Name	Middle Initial	Last Name	Relationship to Insured

PART B

	Yes	No
1. Have you ever had any of the following: heart attack, heart bypass, coronary artery disease, stroke, cancer (other than basal cell skin cancer), treatment for back disorders, insulin dependent diabetes, or diagnosed by a physician with AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) and/or tested positive for HIV (Human Immunodeficiency Virus) or any disease or disorder of the immune system?	❑	❑
2. In the last year, have you been hospitalized for any reason or been recommended to seek: medical advice, treatment, care and/or counseling that has not yet been performed?	❑	❑

PART C

MEDICAL EVIDENCE OF INSURABILITY

Please indicate if the proposed insured has been treated for or diagnosed by a physician or practitioner as having any of the following within the last 10 years: (Circle all applicable condition(s) below.)

1. Adrenal/Pituitary Disorders
2. Alcohol Addiction/Abuse
3. Aneurysm/Stroke
4. Asthma/Chronic Bronchitis
5. Arthritis/Gout/Joint Disorder
6. Birth Defects/Congenital Abnormality
7. Blood Disorder/Transfusion/Hemorrhage
8. Circulatory/Vascular Disorder
9. Colitis
10. Complications of Pregnancy
11. Diagnostic Testing
12. Dizziness/Loss of Consciousness
13. Drug Addiction/Abuse
14. Epilepsy/Seizures/Convulsions
15. Reproductive/Breast Disorders
16. GI Disorder/Ulcer/Crohn's
17. Gonorrhea/Syphilis
18. Headaches
19. Heart Disease, Disorder/Angina
20. High Blood Pressure
21. Immunodeficiency Disorder
22. Kidney/Bladder/Prostate Disorder
23. Liver Disorder/Hepatitis/Cirrhosis
24. Lung Disorder/Respiratory
25. Lupus
26. Lymphatic Disorder
27. Surgery
28. Mental Illness/Emotional Disorder
29. Neurological Disorder/M.S.
30. Pancreatitis
31. Paralysis/Polio Residuals
32. Proctitis/Rectal Disorder
33. Respiratory/Tuberculosis
34. TMJ Disorder
35. Thyroid/Goiter
36. Tumor/Abscess/Cyst
37. Varicose Veins
38. Vision/Hearing Disorders
39. Any Other Health Conditions Not Listed _____
40. Currently taking any Prescription Medication

Any Other Medical Treatment Recommended but NOT YET COMPLETED: _____

PART D

In the spaces below, give details to all conditions circled in Part C by indicating dates, condition number(s), diagnosis, treatment results, duration and outcomes. If necessary, use a separate sheet of paper, dated and signed by the proposed insured. Please use the first line to list the name of the physician who is most likely to have your complete medical records.

Physician's Name and Address	Dates	Condition Number(s)	Diagnosis	Treatment Results
1.				
2.				
3.				
4.				
5.				
6.				
7.				

WARNING: 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 may be committing a fraudulent insurance act, which is a crime.

I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, it's reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that the application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I AGREE that no insurance will take effect unless and until the policy is issued and delivered to the proposed insured(s), the first premium has been paid to and accepted by Central United and there has been no change in the insurability of the Proposed Insured since the date of this application.

If this application is declined, any premiums received by Central United will be refunded.

No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the Application.

Signed at _____
City State Month-Day-Year

XX

Signature of Proposed Insured Date

01THE11

Agent's Signature Agent No.

BENEFITS UNLIMITED, INC. (415) 459-5019

Print Agent's Name Telephone Number

ELECTION FORM

Postal (Central United Life)

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 - OCC3 - 1 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	$600	$22.13
	$700	$25.81
	$800	$29.50
	$900	$33.19
	$1,000	$36.88
	$1,100	$40.56
	$1,200	$44.25
	$1,300	$47.94
	$1,400	$51.63
	$1,500	$55.32
	$1,600	$59.00
	$1,700	$62.69
	$1,800	$66.38
	$1,900	$70.07
×	$2,000	$73.75

Total Bi-Weekly: $73.75 Add $2.00 Fee = Total Allotment: $75.75
(includes any Rider Costs)

EMPLOYEE ID # ☐☐☐☐☐☐☐☐ POSTAL EASE PIN# ☐☐☐☐

SSP Password:_____

Authorized Signature:_____ Date:_____

UNITED STATES
POSTAL SERVICE™

DIRECT DEPOSIT

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

Employee ID

PostalEASE PIN Number

4b. Finance Number

Password

5a. REQUIRED Action (Check ONLY One)

☐ ESTABLISH a Net Check ☐ CANCEL a Net Check ☐ CHANGE a Net Check Financial Organization

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 **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 — Check Digit

0 2 1 4 0 9 1 6 — 9

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

0 1 5

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.