❑ 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:_____

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.**

Type of Account: **Savings** ☒ **Checking** ☐

Authorization Agreement for [name] _____ Routing # _____

⇨⇨(PLEASE ATTACH ONE BANK VOIDED CHECK) Account #: _____

I (we) hereby authorize Beneftis 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 Secuirty #** _____

Signature⇨ _____ **date:** _____