The Prudential Insurance Company of America

751 Broad Street, Newark, NJ 07102

Insurance Specialists, Inc. I 50006

Request for Long Term Disability Coverage Form

Return this completed form to:

Insurance Specialists, Inc.
P.O. Box 2327, Beaufort, SC 29901
Phone: 888-474-1959 Fax: 866-871-2170
E-mail: sales@isi1959.com

Please print all answers using black ink.

1 Member Information

Name of Association _____ Annual Earned Income _____

First Name | MI | Last Name

Street | Apt.

City | State | ZIP code

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

Gender ☐ Male ☐ Female | Height ft. in. | Weight lbs. | Evening Telephone Number

E-mail Address

2 Health Questions

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

Member Yes	Member 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:_____ **You may attach additional sheets of paper if needed.**
		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 disease or disorder
☐	☐	**e.** Diabetes
☐	☐	**f.** Liver or kidney disorders
☐	☐	**g.** Gastrointestinal, stomach, intestine, or genitourinary system disease or disorder, including ulcers or gallstones
☐	☐	**h.** Mental or nervous illness or disorder, alcoholism or drug addiction
☐	☐	**i.** Chronic pain or fatigue syndromes
☐	☐	**j.** Neurological disorders such as Multiple Sclerosis or Parkinson's Disease
☐	☐	**k.** Musculoskeletal disorders including arthritis, back disorder, fractures, or carpal tunnel syndrome
☐	☐	**3. Within the last five years,** have you been diagnosed with or treated by a physician for Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS)?
☐	☐	**4. Within the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
☐	☐	**5. Within the last five years,** have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
☐	☐	**6. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?
☐	☐	**7. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

2 Health Questions

continued from page 1

If you answered "Yes" to any of questions 2-7, please provide full details below.
(If more space is needed, please attach an additional sheet.)

Member	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
☐					
☐					
☐					

Primary Care Physician Information For Member

Name	Date last seen	Telephone

Address

3 Coverage Requested For

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

☐ **Long Term Disability Insurance Plan—**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 monthly earned income.

Member's Monthly Coverage Amount: $_____

Benefit Elimination Period (select one)**:** ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day

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

Optional Benefits: ☐ 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*

4 Contribution Payment Basis

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

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ 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 Plan 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 and instruct any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health care provider that has provided treatment or services to me within the past 5 years ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers,authorized agents,and the MIB, Inc. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont and Wisconsin, 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, drugs, and tobacco, but excludes psychotherapy notes. I also authorize the MIB, Inc. to release any data it may have about me proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I have made to restrict the disclosure of health information do not apply to this Authorization and I instruct any of My Providers to release and disclose my entire medical record without restriction, including without limitation any restrictions on health care items or services for which a health care provider has been paid out of pocket in full. 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) administer coverage; and 3) 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 such a revocation is not effective to the extent that Prudential has taken action in reliance on this Authorization or to the extent that Prudential has a legal right to contest a claim under the insurance contract or to contest the contract itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed to other parties and will not be protected by the HIPAA Privacy Rule. (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 my entire medical record and any other health information concerning me, Prudential may not be able to process an application for coverage. 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 my application, including portions containing health information are submitted to the Plan Administrator, acting for the policy holder, and that the administrator shall forward the application to the insurance company. Furthermore 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 Certificate has been issued while all persons to be insured thereunder are alive; the answers and statements in this application continue to be true and complete until the Effective Date; and the initial premium contribution has been paid. 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.

Please consult Fraud warnings appearing on next page. I have read and understand the terms and requirements of these Fraud warnings.

I have received the Group Life and Disability Income Medical Underwriting Notice included with this form.

X _____ _____

Member Signature Date (mm/dd/yyyy)

By my signature above, I hereby request coverage. I acknowledge that I am a member of the above Association and that I must continue such membership to keep this insurance in force.

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, 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/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. **ALABAMA RESIDENTS** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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. **MAINE and 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. **MARYLAND RESIDENTS** – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **PUERTO RICO RESIDENTS** – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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 change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

This application is to be attached to and made part of the Group Contract.

Please keep this notice for your records.

Long Term Disability coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract series: 83500