Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828 • Portland, Maine 04112-8828

Business Overhead Expense Insurance Application
PIA Services Group Insurance Fund
Group Policy Number: 1059

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes. Answer *all* questions, then sign the Authorization and Agreement.

Section 1: Member Information

1. Member Name: _____
2. Member SSN: _____ 3. Email Address: _____
4. Billing Address: _____ City: _____ State: _____ Zip: _____
5. Home Address: _____ City: _____ State: _____ Zip: _____
6. Date of Birth: _____ ***If you are a resident of Maryland, do not answer 7 and 8*** 7. Place of Birth: _____
8. Citizenship/Country: _____ 9. Sex: ❑ Male ❑ Female 10. Daytime Phone #: _____
11. Are you a member of the National Association of Professional Insurance Agents? ❑ Yes ❑ No
12. Current Occupation/Profession: _____ 13. How many hours a week do you work? _____
14. Please describe your duties: _____
15. Beneficiary: _____ 16. Relationship of Beneficiary to you: _____
17. Application is made for: ❑ New Coverage ❑ Increase Current Amount of Coverage: $ _____
    ❑ Reinstatement following military service. Dates of Service: from _____ to _____ Amount of Coverage: $ _____

Section 2: Plan Selection for Business Overhead Expense Coverage

1. MAXIMUM MONTHLY BENEFIT: $ _____ $500 to $10,000 per month, in increments of $500, not to exceed 100% of your Monthly Insurable Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.
2. MAXIMUM BENEFIT PERIOD (Select one): ❑ 12 Months ❑ 18 Months ❑ 24 Months
3. ELIMINATION PERIOD: 30 Days

Section 3: Other Coverage

If You have Disability Income or Business Overhead Expense insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?	Employer Paid
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No

Section 4: Financial Information

1. Business Type (check one): ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ Limited Liability Partnership
❑ Limited Liability Corporation ❑ S-Corporation ❑ Other (specify): _____

2. Percentage of business owned by you: _____ Number of years owned by you: _____
Number of years business has been in existence: _____

3. Annual earned income from your personal services as reported to the IRS on your personal and/or business federal tax return:
Last Calendar Year: $ _____ Prior Calendar Year $ _____

4. List your total monthly expenses for the business:

Rent or Mortgage Interest Payments	$ _____	Property Taxes	$ _____
Property and Casualty Insurance	$ _____	Postage/Stationary	$ _____
Employee Salaries*	$ _____	Equipment Lease Payments	$ _____
Employee Benefits*	$ _____	Other Miscellaneous*	$ _____
Accounting/Legal Fees	$ _____	Maintenance	$ _____
Malpractice Insurance	$ _____	Utilities	$ _____
Professional Dues & Subscriptions	$ _____	Your Total Monthly Expenses	$ _____
Rent or Mortgage Interest Payments	$ _____	Property Taxes	$ _____

* Do not include salaries, fees, drawing accounts, profits, benefits and other forms of remuneration which are payable to you or to anyone employed in your business who is in the same profession as you, or any member of your family not regularly employed by the business, mortgage payments applied to principal, cost of goods, wares and merchandise of any nature or the cost of the implements of your profession or occupation.

Section 5: Member's Statement of Health

1. a) Height: _____ft. _____in. b) Weight: _____ lbs. c) Weight change last year: _____ lbs.
d) Reason for weight change: (Gain or Loss) _____

2. Name of Personal Physician (if none, please indicate): _____
Physician Address: _____
Date last seen:* _____ Reason: _____ Results: _____
* For residents of MD, report the date, reason and results of the last visit within the previous 7 years

3. In the past 180 days, have you ever been:
a) absent from work, or unable to perform any duty of your occupation, because of sickness or injury? ❑ Yes ❑ No
b) been homebound or hospitalized because of sickness or injury? ❑ Yes ❑ No
If Yes to a) or b), for how many days? _____ Date(s): _____ Reason: _____

4. Have you used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe within the last 12 months? ❑ Yes ❑ No

5. During the past 10 years (7 years in MD; 5 years in IN, KS and MN), have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? ❑ Yes ❑ No

6. During the past 10 years (7 years in MD; 5 years in IN, KS and MN), have you been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details. Except in KS and MN, include conditions for which you have experienced symptoms. For residents of MD, include conditions which you experienced known symptoms.

a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? ❑ Yes ❑ No	d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition? ❑ Yes ❑ No
b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung? ❑ Yes ❑ No	e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease? ❑ Yes ❑ No
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder? ❑ Yes ❑ No	

Section 5: Member's Statement of Health - Continued

f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system? (In ME and WI, excluding HIV)	❑ Yes ❑ No	i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat?	❑ Yes ❑ No
		j) chronic fatigue, Epstein Barr virus, fibromyalgia?	❑ Yes ❑ No
g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for HIV)?	❑ Yes ❑ No	k) complications of pregnancy	❑ Yes ❑ No
h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease?	❑ Yes ❑ No	l) Are you pregnant? If "yes", due date:_____	❑ Yes ❑ No

7. During the past 10 years (7 years in MD; 5 years in IN, KS and MN), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME and WI, excluding HIV) ❑ Yes ❑ No

   A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)

8. During the past 10 years (7 years in MD; 5 years in IN, KS and MN), have you had or been advised by a member of the medical profession to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (In ME, excluding HIV) ❑ Yes ❑ No

9. During the past 10 years (7 years in MD; 5 years in IN, KS and MN), have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital? (in ME, excluding HIV) ❑ Yes ❑ No

10. Are you presently under observation or treatment by a member of the medical profession, or presently have any physical impairment or deformity (in MD, or had known symptoms or known indications of a physical impairment or deformity), or within the past 12 months taken medication (prescription or non-prescription) for any reason? ❑ Yes ❑ No

11. During the past 10 years (7 years in MD; 5 years in IN, KS and MN) have you:

    a) Sought, been advised (in MD, advised by a medical professional), to seek, or received treatment for the use of alcohol, or (except in NC) received counseling for the use of alcohol? ❑ Yes ❑ No

    b) Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised (in MD, advised by a medical professional), to seek, or received treatment for the use of prescribed or non-prescribed drugs, or (except in NC) received counseling for the use of prescribed or non-prescribed drugs; or been arrested for the possession of or use of prescribed or non-prescribed drugs? (With respect to residents of Maryland, do not respond relative to habit forming drugs other than those specifically listed.) ❑ Yes ❑ No

    c) to the best of your knowledge and belief, been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or, except for residents of Florida, been treated for AIDS or ARC? (in ME, excluding HIV) ❑ Yes ❑ No

If you are a resident of CA, CO, CT, ME, ND, NJ, NY or WI do not answer question 12.

12. During the past 10 years (7 years in MD; 5 years in IN, KS and MN) have you tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies? ❑ Yes ❑ No

Section 6: Medical Details (Please provide details if you answered YES to any item in the Member's Statement of Health Section)

Question #	Reason/ Condition	Diagnosis/Treatment/ Results	Name, Address and Phone No. of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work?

Section 7: Fraud Notice

The following Notice applies to residents of Alabama: 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.

The following Notice applies to residents of California: UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

The following Notice applies to residents of Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

The following Notice applies to residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following Notice applies to residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The following Notice applies to residents of Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

The following Notice applies to residents of Kansas: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of fraud as determined by a court of law.

The following Notice applies to residents of Kentucky: 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.

The following Notice applies to residents of Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

The following Notice applies to residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

The following Notice applies to residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

The following Notice applies to residents of New Mexico: 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 civil fines and criminal penalties.

The following Notice applies to residents of New York: 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.

The following Notice applies to residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The following Notice applies to residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

The following Notice applies to residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

Section 7: Fraud Notice - Continued

The following Notice applies to residents of Pennsylvania: 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 subjects such person to criminal and civil penalties

The following Notice applies to residents of Vermont: 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 may be guilty of a crime.

The following Notice applies to residents of Virginia: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may have violated state law.

The following Notice applies to residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The following Notice applies to residents of all other states: 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.

Section 8: Authorization and Agreement

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health, (with respect to residents of Maine, the applicant's authorization does not include disclosure from "other organizations; institutions or persons that has knowledge of the applicant") to disclose the information to: the Unimerica Insurance Company; and, its affiliates ("Unimerica"). This information will be used to determine my eligibility for benefits.

I authorize Unimerica to: obtain; use; and disclose; my medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize Unimerica to disclose the information to the Policy's administrator; or as may be required by law. **I authorize Unimerica, or its reinsurers, to make a brief report of my personal health information to MIB.**

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original. I understand that I have a right to receive a copy of the authorization.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying Unimerica in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right Unimerica has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires 24 months after the date it is signed. With respect to residents of Minnesota, the authorization is valid as long as the applicant is continually insured with Unimerica Insurance Company. With respect to residents of Maine, in addition, revoking the authorization may be the basis for denying benefits for claims submitted after the revocation. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

I request the indicated group coverage for myself. I have not given the agent; or, any other persons any health information not included on this form. I understand that Unimerica is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that, subject to the Deferred Effective Date provisions coverage will not take effect until Unimerica grants its underwriting approval.

Section 8: Authorization and Agreement - Continued

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application. I understand that any pre-existing condition (including any injury, sickness, mental illness or substance abuse) for which: (a) I was diagnosed or received treatment from a physician or other licensed practitioner of the healing arts; or (b) I took any drugs or medications; within the 12 month period prior to my effective date of insurance, will not be covered until the earlier of: (1) the date I have been insured under the policy for 24 months (12 months in MD, MT, SC, SD and UT) after my Effective Date; or (2) except in MT and SD, the date I have been free of treatment for such condition for a one year period ending on or after my Effective Date. Except in ID, MN and ND, I further understand that pre-existing conditions include any symptoms or subjective symptoms that I had within the 12 month period prior to my Effective Date. In Maryland, this limitation does not include a condition that I reveal in this application unless it is listed on an impairment rider attached to the Policy.

With respect to residents of Maine, failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits. **This authorization excludes divulging whether tests for the presence of HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant or any other person to be covered has AIDS/ARC**.

With respect to residents of Minnesota, this authorization excludes information on blood borne pathogens and HIV antibody tests if performed: on criminal offenders or their victims as the result of a crime reported to police; or on any person giving or receiving emergency care including the patient, emergency medical, fire, or police personnel, or any person qualifying for this exemption under Minnesota law, including the Good Samaritan law.

With respect to residents of Virginia, the applicant agrees that a photocopy of this form shall be as valid as the original for the purpose of collecting information in connection with this application. The applicant understands that he, or a person authorized to act on his behalf, is entitled to receive a copy of this authorization form.

Member Signature:_____ Dated: _____

Retain a photocopy of this Enrollment form for your records and return the original to:

Lockton Affinity, LLC

P.O. Box 410679 • Kansas City, MO 64141-0679 • Phone: 800-336-4759 •
EMAIL: pia@locktonaffinity.com