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

Basic Life Insurance Application/Enrollment Form
PIA Services Group Insurance Fund
Group Policy Number:1051

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/Employee Information

1. Member/Employee Name: _____
2. Member/Employee 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 or 8) 7. Place of Birth: _____
8. Citizenship / Country: _____ 9. Sex: ❑ Male ❑ Female 10. Daytime Phone #: _____
11. Your PIA affiliation (Check one):

CLASS 1

- ❑ Individual proprietor, partner, corporate officer, limited Licensed employee of Member Agency liability partner or manager of member Agencies who are principally engaged in the business of the Member Agency and who maintain current membership status in the National Association of Professional Insurance Agents
- ❑ Trust manager of PIA Services Group Insurance Fund
- ❑ Trustees of PIA Services Group Insurance Fund who Maintain current membership status in the National Association of Professional Insurance Agents
- ❑ Persons employed as executive directors, department heads, division heads, or senior staff of the National Association of PIA, a local PIA affiliate or PIA Services Inc.

CLASS 2

- ❑ Licensed employees of Member Agencies
- ❑ Independent Producers who:
  a) work exclusively for a Member Agency:
  b) maintain current membership status in the National Association of Professional Insurance Agents;
  c) receive from the Member Agency a monthly commission which, when combined with any draw against commission, equals an amount not less the minimum wage times 150 hours; and
  d) are certified by the Member Agency as working at least 20 hours per week.

CLASS 3: All other employees of:

- ❑ A Member Agency;
- ❑ PIA Services Group Insurance Fund;
- ❑ National Association of Professional Insurance Agents or its local affiliates; and
- ❑ PIA Services, Inc.

12. If an employee, please provide the name of the Member or Member Agency: _____
13. Current Occupation: _____ 14. How many hours a week do you work? _____
15. Please describe your duties: _____
16. If You are a resident of Massachusetts, are You an active member of the United States Armed Forces? (Army, Navy, Air Force, marine Corp or Coast Guard) ❑ Yes ❑ No
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 Life Coverage

1. Amount of Life Insurance desired: $ _____ Class 1 $50,000; Class 2 $30,000; Class 3 $20,000 (If applying to increase coverage, indicate only the ADDITIONAL amount of Life Insurance desired.)
2. Full Name of Beneficiary: _____ Relationship: _____
3. Full Name of Contingent Beneficiary: _____ Relationship: _____
4. Life Insurance for Dependent Spouse: ❑ Yes ❑ No If yes, please complete the Spouse Life Application.
5. Life Insurance for Dependent Child(ren): ❑ Yes ❑ No Amount of Life Insurance for Dependent Children: $10,000 ($500 for Age 14 days to 6 months)
6. Names and Birth Dates of Dependent Children (if Covered):

Name of Child	*/ Date of Birth*	*Name of Child*	*/ Date of Birth*
	/		/
	/		/
	/		/

Section 3: Other Coverage

If anyone applying for coverage has Other Life Insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Coverage Type	Benefit Amount	Will Coverage be Replaced?*
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

*"Replaced" means you intend to replace, discontinue or change existing Other Life Insurance coverage by applying for the proposed coverage.

Section 4: Financial Information

1. Annual earned income as reported to the IRS on your personal and/or business federal tax return last calendar year: $ _____
2. Net Worth: $ _____

Section 5: 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 Connecticut: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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.

Section 5: Fraud Notice - Continued

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.

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 6: 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.

Section 6: Authorization and Agreement - Continued

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 and, if applicable, for my dependents. 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; the 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, if any coverage will not take effect until Unimerica grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with the application.

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 Vermont, this authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The applicant IS NOT authorizing the company to forward the results of any new test required by the company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

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.

Applicant Signature:_____ Dated: _____

Retain a photocopy of this application 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