LLOYD'S

PFS SPECIALTY RISK UNDERWRITERS

Disability Insurance Application

PART IIA

1a. Name *(First, M.I., Last)*	4. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? ☐ Yes ☐ No *(If "Yes," please provide details in #7.)*
b. Date of Birth *(Mo., Day, Yr.)* c. Sex ☐ Male ☐ Female	
2. Have you ever received treatment for or lost time from work due to drug or alcohol abuse, or been advised to limit your use of alcohol or addictive substances? ☐ Yes ☐ No *(If "Yes," please describe frequency and quantity in #7.)*	5. Have you had any change in weight in the past year? ☐ Yes ☐ No *(If "Yes," please provide details in #7.)*
3. Within the past 10 years, have you used cocaine, marijuana, barbiturates, heroin, or any other narcotic drug except as prescribed by a physician? ☐ Yes ☐ No *(If "Yes," please describe the circumstances, including type of drugs used and the amount, frequency and date last used in #7.)*	6. What is your exact height and weight? ft. in. lbs.

7. Please provide details of "Yes" answers to questions 2-5. Please identify the question number.

8. Have you **ever** had any indication of, or been treated for: *(If "Yes," please provide details in question 12.)*

		Yes	No
a.	Chest pain, high blood pressure, heart disease or other disorders of the heart or blood vessels?	☐	☐
b.	Ulcers, colitis, disease of the stomach, liver, intestines, gallbladder, kidney or urinary bladder?	☐	☐
c.	Seizures, fainting, dizziness, epilepsy, stroke or paralysis?	☐	☐
d.	Nervous, mental or emotional disorder?	☐	☐
e.	Any tumor, cancer, cysts or any disorder of the lymph glands?	☐	☐
f.	Arthritis, gout, recurrent back pain or any disorder of the back, spine, muscles, bones or joints?	☐	☐
g.	Diabetes, thyroid or other endocrine or glandular disorder?	☐	☐
h.	Anemia or any other blood disorder?	☐	☐
i.	Asthma, emphysema, shortness of breath or any disorder of the respiratory system?	☐	☐
j.	Disorder of the eyes, ears, nose or throat?	☐	☐
k.	Drug or alcohol abuse or been advised to limit your use of alcohol or addictive substances?	☐	☐
l.	Any disorder of the reproductive organs (testicles, prostate, breasts, ovaries, etc.)?	☐	☐
m.	Any physical abnormality or deformity?	☐	☐
n.	Allergies or skin disorder?	☐	☐
9a.	Have you ever been diagnosed by a member of the medical profession as having AIDS?	☐	☐
b.	Have you ever had swollen lymph glands, loss of appetite, weight loss, fever, oral thrush or rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause? *(If "Yes," please provide details in question 12.)*	☐	☐
10.	Within the past five (5) years have you: *(If "Yes," please provide details in question 12.)*	☐	☐
a.	Had a check-up, electrocardiogram, x-ray, blood test or diagnostic test?	☐	☐
b.	Had or been advised to have any diagnostic test, hospitalization or surgery?	☐	☐
c.	Been a patient in a hospital, sanatorium or other medical facility?	☐	☐
11.	Your family (parents, brothers, sisters). To the best of your knowledge: *(If "Yes," please provide details in question 12.)*		
a.	Is there any family history of diabetes, cancer or heart disease?	☐	☐
b.	Has anyone requried an organ transplant, or have a condition that may require a transplant in the next five (5) years?	☐	☐

12. If any questions in 8-11 are answered "Yes," please indicate the question number (e.g., 8d) and give **complete** details.

No.	Details or Reason and any current medication	Onset Date	Duration	Result	Name and Address of all Physicians

13. When and for what reason did you last consult a physician? (Please provide details below.)

14. If, in the opinion of the Company, a medical examination by a duly appointed Medical Examiner is necessary as further Evidence of insurability, do you agree to take such examination? ☐ Yes ☐ No

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree a) that this Part IIA Disability Insurance Application shall form a part of any policy issued, and b) that no agent of the Company shall have the authority to waive a complete answer to Application, make or alter any contract, or waive any of the Company's other rights or requirements.

Dated on _____ Witness _____ Covered Individual _____

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Disability Insurance Application

INSTRUCTIONS FOR COMPLETION:

1. Representative must complete the Part IIA in handwriting in the presence of the Covered Individual. Please use black or dark blue ink (as a photocopy of the application becomes part of the policy.)

2. All questions must be answered fully. Amendments will be necessary to complete details of unanswered questions.

3. Name and addresses of doctors and medical facilities must be legible and complete.

AUTHORIZATION

The purpose of this authorization is to allow Pro Financial Services, LLC/Lloyd's of London to determine your eligibility for life or health insurance coverage or a claim for benefits under a life or health policy.

I AUTHORIZE any medical professional, hospital, medical care institution, insurer, Medical Information Bureau, Inc., consumer reporting agency, Social Security Administration, employer, or other person having records or knowledge of me or my family members' physical or mental health, or any other information bearing on my (our) insurability, to give Pro Financial Services, LLC and its reinsurers, or any consumer reporting agency acting on their behalf, any such information, this shall include all information about my (our) medical history, diagnosis, treatment, and prognosis including information regarding alcohol or drug abuse.

I AUTHORIZE Pro Financial Services, LLC/ Lloyd's of London to have a blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorder, or the presence of medication, drugs, or nicotine.

I UNDERSTAND THAT my (our) medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I (we) may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected.

This authorization shall be valid for a period of two years after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such a report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, I do ☐ do not ☐ request to be interviewed.

Signed on _____, _____ _____

(Mo., Day, Yr.) Signature of Covered Individual