on behalf of

LLOYD'S

DISABILITY INSURANCE APPLICATION

Name: First: ____________________ M.I.: ______ Last: ____________________ Suffix: ______________

Date of Birth: _______ / _______ / __________ Social Security Number: _____-____-______ Sex: ❑Male ❑Female

Address: ____

City ____________________ State ______________ Zip Code ____________________

E-mail: ______________________________ Telephone: (_______) _________ - __________

Employer: ____

Occupation: ____________________ Major Duties: ______________________________

____

Specialty: ____________________ Length of Service: ______________________________

FINANCIAL INFORMATION

Annual Income	Current YTD	Last Year
20___ ____________________	20___ ____________________	20___ ____________________

List all existing disability coverage, such as Individual Disability, Group LTD, Salary Continuation Plans, Association Insurance and Disability Buy-Out, which you have in force, are applying for or are reinstating. ❑ None

Company Name	Type of Coverage	Benefit Period	Premium Paid By Employer (Y/N)	Total Benefit Amount	
				Monthly Amount	Lump Sum
1)					
2)					
3)					

Please indicate the type of coverage and the amount of coverage requested.

Permanent Total Disablement — Lump Sum Benefit

Lump Sum Benefit requested: $____________________
(from $250,000 up to $2,000,000)

Elimination Period: Twelve Months

MEDICAL HISTORY

1. Height: __________ Weight: __________
2. Are you currently experiencing any symptoms, signs or other manifestations of physical or mental illness? Yes No If Yes, please provide details: ______________________________
3. When and for what reason did you last consult a physician? ______________________________
   What was the outcome? ______________________________
4. Are you currently scheduled for a medical screening, diagnostic test, hospitalization or surgery? Yes No If Yes, please provide details: ______________________________

on behalf of

Name: ____________________

MEDICAL HISTORY CONTINUED

5. Within the last five (5) years have you ever had any health screening or investigation(s) with adverse results? Yes No If Yes, please provide details:____

6. Have you had any periods of ill-health requiring time off work for a period of 5 days or more in last 3 months or 10 days or more in last 24 months? Yes No If Yes, please provide details:____

7. Do you take any prescribed or over the counter medication(s) ? Yes No If Yes, please provide details: _________________
____

8. Are you currently or in the last five (5) years have you experienced: Cardiovascular, Respiratory, Abdominal, Psychiatric/ Psychological, Muscular, Skeletal, Neurological, Genitourinary, Gynecological, Haematological, Dermatological, Rheumatological, or other Multi-system conditions? Yes No If Yes, please provide details: ___________________________________
____

9. In your medical opinion, are you aware of any physical or mental symptom, signs, test results, other circumstances or specific medical conditions, whether formally diagnosed or not, that may impact your health and fitness to practice now or in the future? Yes No If Yes, please provide details:____
____

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree a) that this Disability Insurance Application (pages 1 and 2) shall form a part of any policy issued, and b) that no Agent/Representative of the Company shall have the authority to waive a complete answer to any question on this Application, transfer insurability, make or alter any contract, or waive any of the Company's other rights or requirements.

Changes or corrections made by the Company above are ratified by the Policyholder upon acceptance of a contract containing this Application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation, amendments as to plan, amount, age at issue, classification, or benefits will be made only with the Policyholder's written consent.

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, as determined by a court if competent jurisdiction.

Signed on: ______________________________ ______________________________________

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

Please Email, Fax or Mail This Form To:

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