LLOYD'S

PFS SPECIALTY RISK UNDERWRITERS

Disability Insurance Application

PART I

Please complete the following. I (we) hereby apply for a new policy of insurance conforming to the specifications below.

SPECIFICATIONS

1a. Name *(First, M.I., Last)*	b. Covered Individualôs SS# __ __ __ - __ __ - __ __ __ __	c. Sex ☐ Male ☐ Female
d. Date of Birth *(Mo., Day, Yr.)*	e. Age nearest Birthday	f. Place of Birth *(State)*
2a. Residence *(No., Street, City, State & Zip Code)*		b. Phone Numbers *(Work)* *(Home)*
3a. Regular Occupation		b. How long so employed?

c. Are you currently engaged in your regular occupation on a full-time basis without any medical restrictions? ☐ Yes ☐ No
If "No," please provide details.

d. List and describe all duties of your regular occupation and any other occupation.

e. Name of employer and nature of business.

f. Place of Business *(No., Street, City, State & Zip Code)*

4a. Loss Payee *(Recipient of benefits) AND relationship to Covered Individual.*	b. Loss Payeeôs Tax I.D. # or SS# __ __ __ __ __ __ __ __ __

5a. Policyholder AND relationship to Covered Individual.

b. If Policyholder is other than the Covered Individual, Policyholderôs SS # or Tax I.D. #
SS # __ __ __ - __ __ - __ __ __ __ or Tax I.D. # __ __ - __ __ __ __ __ __ __

c. If Policyholder is other than an individual, indicate whether a
☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Subchapter S Corporation

6a. To Whom shall premium notice be sent?
☐ To both Covered Individual and Policyholder ☐ To Covered Individual Only
☐ To Policyholder Only **(Policyholder must sign Application)**

b. If Insured is to receive premium notices, where should they be sent?
☐ Covered Individualôs Residence ☐ Covered Individualôs Business ☐ Other

c. If Policyholder is to receive premium notices, where should they be sent? *(No., Street, City, State & Zip Code)*

7. **AMOUNT REQUESTED**	**Monthly Benefit**	**Elimination Period**	**Benefit Period**
Temporary Total Disability (TTD)			
	Lump Sum Benefit	**Waiting Period**	**Benefit Period**
Permanent Total Disability (PTD)			Not Applicable

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Disability Insurance Application

8a. Do you have any other disability insurance currently in force? ☐ Yes ☐ No
(If "Yes," complete the information below.)

Company Name	Type of Coverage	Policy Number	Monthly Amount	Next Premium Due Date	Is Premium Employer Paid?

8b. Do you intend to cancel any of the above insurance coverage at, or prior to their next premium due dates?
☐ Yes ☐ No

9. List all existing disability coverage, such as Individual Disability, Accident and/or Sickness, Group LTD, Salary Continuation Plans, Association Insurance and Disability Buy-Out. *(If "None," please state.)*

Company Name	Type of Coverage	Benefit Period	Premium Paid By Employer	Total Benefit Amount			SISB Amount (if any)
				Amount	Monthly	Lump Sum (DBO)	

10. Are you negotiating for any other Disability or Life Insurance? ☐ Yes ☐ No
(If "Yes," please provide details below.)

Company Name	Type of Coverage	Face or Monthly Amount	Disability

11. Are you eligible for
State Disability Benefits ☐ Yes ☐ No Workerôs Compensation ☐ Yes ☐ No Social Security ☐ Yes ☐ No

12. SPORTING ACTIVITIES	13. OTHER ACTIVITIES AND HOBBIES

14. Amount of payment submitted with this Application?

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 Companyôs other rights or requirements.

Changes or corrections made by the Company and noted in Item 15 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 Policyholderôs 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.

Dated: *(Mo., Day, Yr.)*

I hereby certify that I have truthfully and accurately recorded all of the Information supplied by the Applicant Witness ï Licensed Representative	Signature of Covered Individual

LLOYD'S

PFS SPECIALTY RISK UNDERWRITERS

Disability Insurance Application

TAX CERTIFICATION FOR EMPLOYER PURCHASED INSURANCE ONLY

Certification ï Under penalties of perjury, I, Policyholder of the policy applied for, certify that:

1) The number shown below is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**

2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instruction - You must cross out item (2) if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Taxpayer Identification Number (of Policyholder if other than Covered Individual) Enter the identification number in appropriate box. For most individual taxpayers, this is the social security number. SS # __ __ __ - __ __ - __ __ __ __ or Employer I.D. # __ __ - __ __ __ __ __ __ __	Backup Withholding on Accounts Opened After 12/31/83 Check the box if you are NOT subject to backup witholding under the provisions of section 3406(a) (1) (C) of the Internal Revenue Code. ☐

Certification – Under the penalties of perjury, I certify that the information provided on this Required Taxpayer Identification Number form is true, correct and complete

Signed on _____ _____

(Mo., Day, Yr.) Signature of Policyholder

CERTIFICATION BY REPRESENTATIVE

The Licensed Representative who witnessed the signature(s) on this Application certifies that:

1) He/She asked all the questions on this application and recommends this risk to the Company without reservation.

2) The policy being applied for:
is not intended to replace existing Disability Insurance ☐ is intended to replace existing Disability Insurance ☐

Licensed Representative	Signature	Share %
Second Licensed Representative	Signature	Share %
Third Licensed Representative	Signature	Share %