

LLOYD'S LONDON PERSONAL ACCIDENT AND SICKNESS APPLICATION

HCC SPECIALTY UNDERWRITERS, INC. - ADMINISTRATOR

- Instructions:**
- Complete only in the presence of the Proposed Insured
 - Please PRINT in black ink and initial all changes
 - Answer all questions in their entirety - Unanswered questions will delay the processing
 - "N/A" is an unsatisfactory answer and will not be accepted
 - USE OF LIQUID WHITEOUT OR LIQUID PAPER will not be accepted

1. Proposed Insured (You): _____

Address: _____
 (Street)
 _____ / _____ / _____
 (City) (State) (Zip)

Soc. Sec. No: ____ / ____ / ____ Sex: M F Weight: _____ Height: _____

Date of Birth: ____ / ____ / ____ Place of Birth: _____
 Month Day Year

2. Assured (Applicant and Owner if other than Proposed Insured): _____

Address: _____
 (Street)
 _____ / _____ / _____
 (City) (State) (Zip)

Soc. Sec. No: ____ / ____ / ____ Tax I.D. Number: ____ / ____ / ____

3. Employer: _____

Address: _____
 (Street)
 _____ / _____ / _____
 (City) (State) (Zip)

4. Name of Beneficiary (if other than Proposed Insured): _____

Soc. Sec. No: ____ / ____ / ____ Tax I.D. Number: ____ / ____ / ____

Beneficiary Address: _____
 (Street) (City) (State) (Zip)

Relationship to Proposed Insured: _____

5. Occupation of Proposed Insured: _____

Job Title: _____

6. Nature of Business: _____

Describe, in order of importance, all major duties of your occupation.

<u>Description of Duties</u>	<u>% of time devoted to this activity</u>
_____	_____
_____	_____
_____	_____
_____	_____

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7. PERSONAL FINANCIAL INFORMATION OF THE PROPOSED INSURED

a) Earned income means the compensation which you receive for work or personal services, after business expenses, but before any other deductions, as reported for federal income tax purposes on IRS Form 1040.

Earned income does not include passive or unearned income from dividends, interest, rentals or royalties. It is not Adjusted Gross Income.

Fill in the amounts that are (or will be) shown on your federal income tax forms and supporting schedules. Do not enter any amounts that are not reported to the IRS.

	<u>Current Year</u> Estimated Jan 1 - Dec 31 20 _____
b) EARNED INCOME	
1. Salary or Wages from Form W2	_____
2. Sole Proprietor Net Profit from 1040 Schedule C	_____
3. Share of Partnership or S Corp Non-Passive Income from 1040 Schedule E	_____
4. Pension Plan Contributions or Elective Deferred Compensation which would cease if the Proposed Insured were disabled	_____
5. Bonus, Commission or Other Earned Income from this occupation (explain in Remarks below)	_____
6. Other Earned Income from any other full or part time work (explain in Remarks below)	_____
TOTAL EARNED INCOME (Add above amounts)	_____
c) UNEARNED INCOME including passive income, if it exceeds \$20,000 in either of the last two years. If not applicable, so state.	_____
d) NET WORTH Is your net worth greater than \$4,000,000? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, describe your net worth in detail. Show current value less indebtedness.	
Cash, savings, stocks and bonds \$ _____	Personal property \$ _____
Business \$ _____	Personal residence \$ _____
Other real estate \$ _____	Other \$ _____

e) Explain any fluctuations in income that exceed 20% of the prior year, or any special circumstances that may affect your earned income, in the Remarks section below.

Remarks: _____

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8. Are You now at work at least 30 hours a week in this occupation? Yes No

9. Number of years in this occupation? _____ with this Employer? _____

10. Former occupation, if changed within two years _____

11. Do You have any other part or full time jobs? Yes No

If Yes, describe: _____

12. If an owner, percentage owned _____% Years owned _____ Number of Employees _____

13. Type of Business Entity: _____ Sole Proprietor _____ Partnership _____ S Corp _____ C Corp

Other (Describe): _____

14. List all disability insurance You now have in Force or have applied for in all companies:

If NONE, check here: _____

Code Type of Insurance: IND = Individual G = Group A = Association I = In Force P = Pending Or Date of Eligibility

Insurance Company	Type: Personal Disability Income/Key Person/Overhead/ Buy Out	Type: IND, G or A	Amount of Lump Sum OR Monthly Indemnity	Benefit Period Accident/Sickness	I, P or Date of Eligibility

15. Will You become eligible for group disability income insurance in the next six months? Yes No

16. Do you pay Social Security taxes (FICA or Schedule SE)? Yes No

17. REPLACEMENT

Will this Lloyd's Policy replace any other disability insurance? Yes No

If yes, provided details below:

When issuing any insurance as a result of this Personal Accident and Sickness Application, the Underwriters will rely on the fact that the Proposed Insured and/or the Assured and/or the Employer can and will permanently terminate the coverage(s) listed below by the next premium due date following delivery of the Lloyd's Policy. The Underwriters may contact any listed insurer after the date shown to confirm that the coverage has been permanently terminated.

Insurance Company	Type: Personal Disability Income/Key Person/Overhead/ Buy Out	Group or Association Name	Policy No.	Amount to be Replaced	Next Premium Due Date & Mode

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HEALTH HISTORY

1. Proposed Insured: _____

Date of Birth: ____/____/____ Sex: M [] F [] Occupation: _____
Month Day Year

2. Hospitalizations:

Have You ever been a patient, either inpatient or outpatient, in a hospital, clinic or other medical facility? Yes [] No []
If Yes, please provide full details. Include all years, name of facilities, duration of injury, sickness, surgery and treatment.

3. Medications:

a. Do You presently take any prescribed medicines? Yes [] No []
If Yes, list name(s), dosage, how often You take it and reason(s) for taking each.

b. During the past five (5) years, have You taken any prescribed medicines (including any cortisone shots or any pain reducing or anti-inflammatory medications or treatments)? Yes [] No []
If Yes, list name(s), dosage, how often You took it and reason(s) for taking each.

c. Do You presently take any non-prescription (over-the-counter) medicine(s) or tonics? Yes [] No []
If Yes, list name(s), dosage, how often You take it and reason(s) for taking each.

4. Have You ever suffered from or ever been medically treated by a physician, chiropractor, psychiatrist, psychologist or drug & alcohol or mental counselor for:

a. glaucoma, cataracts, failing vision not corrected with glasses or contact lenses, persistent hoarseness, loss of hearing or any other disease, injury, syndrome or disorder of the eyes, ears, nose, mouth or throat? Yes [] No []

b. neuritis, sciatica, arthritis, gout, or any other disease, syndrome or disorder of the muscles, nerves, cartilage or bones; including but not limited to the spine, back, knees, shoulders, or elbows or any other joints? Yes [] No []

c. chest pain, palpitation, arrhythmia, heart attack, angina, high blood pressure, heart murmur or any other cardiovascular disease, syndrome or disorder of the heart? Yes [] No []

PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

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HEALTH HISTORY

- d. colitis, ulcer, hernia, diverticulitis, hepatitis, or any other disease, syndrome of the stomach, intestines, liver, gall bladder, rectum or pancreas? Yes No
- e. shortness of breath, persistent cough, asthma, tuberculosis or any other respiratory disease, syndrome or disorder? Yes No
- f. any sexually transmitted disease, sugar, albumin protein, blood or pus in the urine or an infection or disorder of the kidneys, bladder, urinary tract, prostate or reproductive organs? Yes No
- g. dizziness, fainting, convulsions, seizures, severe or persistent headaches, depression, stress, chronic fatigue, mononucleosis, paralysis, stroke or any emotional, nervous, behavioral or mental problem, disease, syndrome, disorder or illness? Yes No
- h. unexplained weight gain or loss of more than 20 pounds, diabetes or any other disease, syndrome, or disorder of the thyroid, pituitary, adrenal or parathyroid gland? Yes No
- i. allergies or any other disease, syndrome or disorder of the skin or lymph glands? Yes No
- j. hysterectomy or prostatectomy or any other disease, syndrome or disorder of the breasts, uterus, tubes, ovaries, vagina, penis, prostate or testicles? Yes No
- k. anemia, hemophilia, clotting disorder, leukemia, or any other disease, syndrome or disorder of the blood or blood vessels? Yes No
- l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? Yes No
- m. cysts, tumor or cancer, either benign or malignant? Yes No
- n. **ANY OTHER INJURY, ILLNESS, SICKNESS, DISEASE OR SYNDROME, CONGENITAL DEFORMITY, ABNORMALITY OR DISORDER NOT LISTED OR MENTIONED ABOVE?** Yes No

5. Have you:

- a. used or abused marijuana, cocaine, heroin, morphine, barbiturates, amphetamines, hallucinogens or any other drug? Yes No
- b. sought or received or been recommended to receive advice or treatment of, or been arrested for the possession of, use or abuse of alcohol or drugs? Yes No

6. Has any BLOOD RELATIVE of Yours ever suffered from a stroke or cancer, heart, or kidney, or diabetes, or high blood pressure disease, syndromes or disorders or mental or emotional disease, syndromes or disorders? Yes No

7. Have you:

- a. within the past five (5) years, obtained license or participated in hunting, piloting, parachuting, sky diving, snow skiing, water skiing, scuba diving, motor racing, or any other similar type sport(s) or activity(ies)? Yes No

If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

- b. Are You currently or do You intend to obtain license or participate in any sport(s) or similar type of activity(ies) as shown in 7.a. above? Yes No

If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

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HEALTH HISTORY

8. Have you ever been convicted of a felony (including a plea of guilty)? Yes No
If Yes, provide reason(s) and date(s) of each such occurrence.

9. Have you ever been convicted of a misdemeanor (including a plea of guilty)? Yes No
If Yes, provide reason(s) and date(s) of each such occurrence.

PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

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Continue Full, Written Details of All Questions Answered "Yes"

A signed Notice and Authorization to obtain Information must be attached for this to be a complete part of this Application

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NOTICE TO PROPOSED INSURED

As a part of Our normal procedure for processing Your application We may get an investigative consumer report. Information may be secured through personal interviews with your friends, neighbors and others with whom You are acquainted. This report typically contains information as to Your character, general reputation, personal characteristics, and mode of living. Within a reasonable period thereafter, You have the right to request in writing a complete and accurate disclosure of additional information concerning the nature and scope of this report, including the name and address of the consumer reporting agency to whom the request was made. Upon the furnishing to You of the name and address of the consumer reporting agency to whom the request was made, We will also inform You that You may inspect and receive a copy of such report by contacting such agency. Please address Your request to "Underwriting Department," HCC SPECIALTY UNDERWRITERS, INC., 401 Edgewater Place, Suite 400, Wakefield, MA 01880.

These reports are made in Your best interests, in that We try to be sure that Insureds meet certain standards so that We can continue to offer coverage at the lowest possible cost to all who qualify.

**NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU
Please Read Carefully**

Information regarding Your insurability will be treated as confidential. We may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

We may also make information in Our file available to reinsurance companies and to other life insurance companies to whom You may apply for life or health insurance, or to whom You submit a claim for benefits.

Upon receipt of a request from You, the Bureau will arrange disclosure of any information it may have in Your file. (Medical information will be disclosed only to Your attending physician.) If You question the accuracy of information in the Bureau's file, You may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. For U.S residents, the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

For Canadian residents, the Canadian Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

AUTHORIZATION

You hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of You or Your health, to give to the Underwriters and/or the Insurer any such information, to the extent permitted by law. You also hereby authorize the Underwriters and/or the Insurer to procure or cause to be prepared an investigative consumer report. You expressly waive under this application, all provisions of the law prohibiting disclosure of information obtained as a result of Your authorization, and You expressly authorize such disclosures and authorize testimony as to such information. You acknowledge receipt of the "NOTICE TO PROPOSED INSURED". A photographic copy of this acknowledgment shall be as valid as the original.

Date: _____
Month / Day / Year

Signature of Proposed Insured (Referred to as "You", "Your")

Date: _____
Month / Day / Year

Signature of Witness