

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 Agreement and Authorization.

Section 1: Member Information

1. Member Name: _____
2. Member SSN: _____-- _____-- _____ 3. Email Address: _____
4. Billing Address: _____ City: _____ State: _____ Zip: _____
5. Home Address: _____ City: _____ State: _____ Zip: _____
6. Date of Birth: ____/____/____ 7. Place of Birth: _____ 8. Citizenship/Country: _____
9. Sex: Male Female 10. Daytime Phone #: _____-- _____-- _____
11. Are You a member of the **Oregon Medical Association**? Yes No 12. Original Member Date ____/____/____
13. Current Occupation / Profession: _____ 14. How many hours a week do you work? _____
15. Please describe your duties: _____
16. Beneficiary _____ 17. Relationship of Beneficiary to you: _____
18. Application is made for: New Coverage
- Increase / Certificate No.: _____ Current Amount of Coverage: \$ _____
- Reinstatement / Certificate No.: _____ Amount of Coverage: \$ _____

Section 2: Plan Selection for Disability Income Coverage

1. MAXIMUM MONTHLY BENEFIT: \$ _____ (\$500 to \$6,000 per month, in increments of \$100, not to exceed 70% of your Annualized Monthly Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.)
2. MAXIMUM BENEFIT PERIOD: (Select one) Plan 7-7 (84 Months) Plan 65-65 (To Age 65)
3. ELIMINATION PERIOD: (Select one) 60 days 90 days 180 days
4. OPTIONAL BENEFITS: (Select Option desired)
- Catastrophic Disability Benefit. Monthly Benefit: \$ _____ (\$500 to \$10,000 per month, in increments of \$100)
- Cost of Living Adjustment for Catastrophic Disability Benefits
- Cost of Living Increase Benefit on Total Disability and Residual Disability Benefits

Section 3: Other Coverage

If You have Disability Income insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?	Employer Paid
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4: Financial Information

1. Business Type (check one): Proprietorship Partnership Corporation Limited Liability Partnership
 Limited Liability Corporation S-Corporation Other (specify): _____
2. Percentage of business owned by you: _____ Number of years owned by you: _____
 Number of years business has been in existence: _____
3. Annual earned income from your personal services as reported to the IRS on your personal and/or business federal tax return:
 Last Calendar Year: \$ _____ Prior Calendar Year \$ _____

Section 5: Member's Statement of Health

1. a) Height: _____ ft. _____ in. b) Weight: _____ lbs. c) Weight change last year: _____ lbs.
 d) Reason for weight change: (Gain or Loss) _____
2. Name of Personal Physician (if none, please indicate): _____
 Physician Address: _____
 Date last seen: _____ Reason: _____ Results: _____
3. During the past 10 years have you tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies? Yes No
4. In the past 180 days, have you ever been:
 a) absent from work, or unable to perform any duty of your occupation, because of sickness or injury? Yes No
 b) been homebound or hospitalized because of sickness or injury? Yes No
- If Yes to (a) or (b), for how many days? _____ Date(s): _____ Reason: _____

5. Have you used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe within the last 12 months? Yes No
6. During the past 10 years, have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? Yes No
7. During the past 10 years, have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details.

a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No	f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system <input type="checkbox"/> Yes <input type="checkbox"/> No
b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung? <input type="checkbox"/> Yes <input type="checkbox"/> No	g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No
e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	j) chronic fatigue, Epstein Barr virus, fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
	k) complications of pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No
	l) Are you pregnant? If "yes", due date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 5: Member's Statement of Health --Continued

8. During the past 10 years, have you had, been told you have, or been treated for a disease or disorder of the blood? Yes No
 A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)
9. During the past 10 years, have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? Yes No
10. During the past 10 years, have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital? Yes No
11. Are you presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason? Yes No
12. During the past 10 years have you:
- a. Sought, been advised to seek, or received counseling or treatment for the use of alcohol? Yes No
 - b. Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received counseling or treatment for the use of prescribed or non-prescribed drugs; or been arrested for the possession of or use of prescribed or non-prescribed drugs? Yes No
 - c. been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
13. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring? Yes No
14. During the past 10 years have you used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb? Yes No
15. During the past 10 years have you had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application? Yes No

Section 6: Medical Details (Please provide details if you answered YES to any item in the Member Statement of Health Section)

If you need more space, attach separate sheet with additional information.

Question #	Reason/ Condition	Diagnosis/Treatment/ Results	Name, Address & Phone No. of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work

Section 7: Fraud Notice

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 may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

Section 8: Agreement and Authorization

I hereby declare that all the statements made in this application 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, subject to the policy's Deferred Effective Date provisions, coverage will not become effective until Unimerica Insurance Company ("Unimerica") grants its underwriting approval. I understand that any condition which is excluded under the Policy will not be covered at any time.

I hereby authorize Unimerica to give information about me to any organization administering the coverage for which I am applying or as required by law. I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, to give Unimerica and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance.

I understand that I may revoke this authorization at any time by sending a written revocation to Unimerica at the address below. 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 an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, Unimerica may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws.

I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed.

I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation.

I also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

Member Signature: _____ Dated: _____

Retain a photocopy of this application for your records and return the original to:

**The Partners Group
11740 SW 68th Parkway, Suite 200
Portland, OR 97223**

Unimerica Insurance Company Insurance Information Practices Notice

Our Underwriting Procedures

For certain types of coverage, we require proof of insurability to determine if you are eligible for the coverage you requested. We review all of the information **in your application** Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your application is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See “Notice Regarding MIB, Inc.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with Unimerica Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Unimerica Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112.

Unimerica Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



NOTICE AND CONSENT FOR BLOOD, URINE & SALIVA WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

Insurer: _____

THE HIV ANTIBODY TEST

To evaluate your insurability, the Insurer named above has requested that you provide a specimen sample of your blood, urine or saliva for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A series of tests will be performed by a licensed laboratory through medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, it is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when infection occurred within the previous 3-6 months prior to the test.

MEANING OF TEST RESULTS

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

COUNSELING

Many public health organizations have recommended that before taking an AIDS-related test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling at your own expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have any questions or concerns, you may wish to consult your own physician or health care provider. A list of counseling resources is provided for your information.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the result means, you are asked to list your personal physician so that the Insurer may know whom to contact with those results.

Name of Physician: _____ **Address** _____

CONFIDENTIALITY OF TEST RESULTS

All test results are treated confidentially. The laboratory will report them only to the Insurer. The test results may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to reinsurers, involved in the underwriting process. The test results may be released to an insurance medical information exchange using only general codes that include results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. No other disclosure will be made of the results except as required by law.

CONSENT

I have read and I understand this Notice of Aids Virus (HIV) Antibody Testing and Consent for Testing. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured (Please Print)

Date

Signature of Proposed Insured

Date