Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828, Portland, Maine 04112-8828

Disability Income Insurance Application
For Members of the Boston Bar Association
Policy Number: 1197 issued to
Trustees of the Association Member Benefit Trust

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 Boston Bar Association? ☐Yes ☐ No

12. Current Occupation / Profession:_____ 13. How many hours a week do you work? _____

14. Please describe your duties: _____

15. Beneficiary _____ 16. Relationship of Beneficiary to you: _____

17. Application is made for: ☐ New Coverage

☐ Increase existing If increasing: Current Amount of Coverage: $_____

Section 2: Plan Selection for Disability Income Coverage

1. MAXIMUM MONTHLY BENEFIT: $_____ ($500 to $5,000 per month, in increments of $100, not to exceed 60% 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) ☐ 24 Months ☐ 60 Months ☐ To Age 65

3. ELIMINATION / WAITING PERIOD: (Select one) ☐ 90 days ☐ 180 days

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
					☐Yes ☐ No	☐Yes ☐ No
					☐Yes ☐ No	☐Yes ☐ No
					☐Yes ☐ No	☐Yes ☐ No
					☐Yes ☐ No	☐Yes ☐ No
					☐Yes ☐ No	☐Yes ☐ No
					☐Yes ☐ No	☐Yes ☐ 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: _____ 3. Number of years owned by you: _____

4. 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. 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:_____

4. 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

5. During the past 10 years (5 years in IN and KS), have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? ☐Yes ☐ No

6. During the past 10 years (5 years in IN and KS), 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. Except in KS, include conditions for which you have experienced symptoms.

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

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

7. During the past 10 years (5 years in IN and KS), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME, excluding HIV) ☐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.)

8. During the past 10 years (5 years in IN and KS), have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (In Maine, excluding HIV) ☐Yes ☐ No

9. During the past 10 years (5 years in IN and KS), 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? (in ME, excluding HIV) ☐Yes ☐ No

10. 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

11. During the past 10 years (5 years in IN and KS) 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) ? (in ME, excluding HIV) ☐Yes ☐ No

If you are a resident of CA, CO, ME, ND, NJ, or WI do not answer question 12.

12. During the past 10 years (5 years in IN and KS) have you tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies? ☐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

The following Notice applies to residents of NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

The following Notice applies to residents of NY: 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 not to exceed five thousand dollars and the stated value of the claim for each such violation.

The following Notice applies to residents of AR, LA, MN, NM, VA, and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, civil and criminal penalties.

The following Notice applies to residents of all other states: 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: _____

The following additional notice applies *only* to residents *of Maine*: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS/ARC. Residents of Maine should also note that failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

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

USI AFFINITY

12 Gill Street
Suite 5500
Woburn, MA 01888
617-423-6448
1-800-747-1018

Unimerica Insurance Company
Notice of Privacy Policy and Practices

Purpose of this Notice

Unimerica Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

Types of Personal Information

We Collect We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal Information

We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information

We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

Individual Rights to Access and Correct Personal Information

We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at Unimerica Workplace Benefits, Mail Route MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

Further Information

We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following Unimerica Insurance Company affiliates:

For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Eyecare of North Carolina, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.