Business ValueGuard™

Application

Questions? Call 800-696-1791 "Disability Protection For Your Business"

Instructions: Print in black and initial all changes • Answer all questions in their entirety • Any unanswered questions will delay the processing • "N/A" or "None" are unsatisfactory answers and will not be accepted.

Before any question is answered read carefully the declaration at the end of this proposal, which must be signed.

1. Policyholder/Assured: ______________________
   (if other than proposed insured)
   Address: ______________________
   Street
   ______ | ______ | ______
   City State Zip Code

2. Proposed Insured: ______________________
   Social Security No.: ___ | ___ | ___ Sex: ☐ Male ☐ Female Weight: ______ Height: ______

3. Date of Birth: ______________ Place of Birth: ______________
   (month/day/year)

4. Residence of Proposed Insured: ______________________
   Street
   ______ | ______ | ______
   City State Zip Code

5. Occupation: ______________________

6. Policy Beneficiary: i. in respect of disability: ______________
   ii. in respect of death: ______________

7. Nature of Business or Occupation in which you are engaged (if more than one, state all). If your duties are not solely of an office or administrative nature please give details.
   ____
   ____

8. State period of insurance and commencement date required.
   ____
   ____

9. For which benefits are you applying? Please provide copies of the past 3 years tax returns as proof of income.

   Business Overhead Expense Benefits: $ ______________ per month

   Permanent Total Disability: $ ______________ lump sum

10. If Monthly Disability Benefits are requested, the following will apply:
    a. the Elimination Period required: ☒ 90 days
    b. the Maximum Benefit period required: 9 months

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11. Do you intend to travel extensively or reside overseas during the period of this policy? ☐ Yes ☐ No
If yes, please explain:

____

____

12. Have you ever had any Life, Health or Accident insurance ever canceled or declined? ☐ Yes ☐ No
If yes, please provide reason(s) for declination, special terms and/or conditions:

____

____

13. Have you and/or Policyholder/Assured ever made any claim(s) against an insurer or any self-insured plan for disability resulting from injury or sickness? ☐ Yes ☐ No
If yes, please provide all details:

____

____

14. Are you now insured against disability resulting from accident or illness? ☐ Yes ☐ No
If yes, with whom and what amount and monthly benefits?

____

____

15. Can you confirm that the monthly benefits under all Policies carried by you, including that now applied for, do not exceed your average monthly income? ☐ Yes ☐ No
If no, please provide details:

____

____

16. Do you anticipate undertaking more than 20 air flights per year or flying other than as a fare paying passenger? ☐ Yes ☐ No
If yes, please provide details:

____

____

17. Have you within the past (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, please provide details:

____

____

18. Have you ever been convicted of a felony or misdemeanor (including a plea of guilty)? ☐ Yes ☐ No
If yes, please provide dates and reasons:

____

____

19. Primary Care Physician
a. Name & Address: _______________
b. Date & Reason Last Seen: _______________
c. Results of Last Visit: _______________

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20. Last Healthcare Provider Seen:
    a. Name & Address: ______________________________
    b. Date & Reason Last Seen: ______________________________
    c. Results of Last Visit: ______________________________

21. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?

a. Eyes ☐ Yes ☐ No
b. Ears ☐ Yes ☐ No
c. Nose ☐ Yes ☐ No
d. Cyst ☐ Yes ☐ No
e. Gout ☐ Yes ☐ No
f. Knees ☐ Yes ☐ No
g. Back/spine/neck ☐ Yes ☐ No
h. Skin ☐ Yes ☐ No
i. Liver ☐ Yes ☐ No
j. Heart ☐ Yes ☐ No
k. Blood ☐ Yes ☐ No
l. Bones ☐ Yes ☐ No
m. Throat ☐ Yes ☐ No
n. Hernia ☐ Yes ☐ No
o. Cancer ☐ Yes ☐ No
p. Bladder ☐ Yes ☐ No
q. Muscles ☐ Yes ☐ No
r. Kidneys ☐ Yes ☐ No
s. Glands ☐ Yes ☐ No
t. Thyroid ☐ Yes ☐ No
u. Pancreas ☐ Yes ☐ No
v. Diabetes ☐ Yes ☐ No
w. Chest pain ☐ Yes ☐ No
x. Headaches ☐ Yes ☐ No
y. HIV/AIDS ☐ Yes ☐ No
z. Sleep apnea ☐ Yes ☐ No

aa. Gall bladder ☐ Yes ☐ No
bb. Convulsions ☐ Yes ☐ No
cc. Concussions ☐ Yes ☐ No
dd. Blood vessels ☐ Yes ☐ No
ee. Lymph nodes ☐ Yes ☐ No
ff. Intestinal tract ☐ Yes ☐ No
hh. Urinary system ☐ Yes ☐ No
ii. Arthritis/joints /rheumatism ☐ Yes ☐ No
jj. Nervous system ☐ Yes ☐ No
kk. Growth/tumor ☐ Yes ☐ No
ll. Unconsciousness ☐ Yes ☐ No
mm. Circulatory system ☐ Yes ☐ No
nn. Fainting/dizziness ☐ Yes ☐ No
oo. Paralysis/weakness ☐ Yes ☐ No
pp. High blood pressure ☐ Yes ☐ No
qq. Disorder of the brain ☐ Yes ☐ No
rr. Lungs ☐ Yes ☐ No
ss. Asthma ☐ Yes ☐ No
tt. Allergies ☐ Yes ☐ No
uu. Tuberculosis ☐ Yes ☐ No
vv. Respiratory system ☐ Yes ☐ No
ww. Reproductive system ☐ Yes ☐ No
xx. Digestive system/stomach ☐ Yes ☐ No
yy. Are you now pregnant? ☐ Yes ☐ No
zz. Any condition not mentioned previously? ☐ Yes ☐ No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

(Use additional sheets if needed)

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22. Have you ever suffered from hernia, lower back strain, disc lesion or other physical defect of a chronic or recurring nature?
If yes, please provide details: ☐ Yes ☐ No

____

____

23. Have you ever suffered from any heart condition, hypertension, varicose veins, nervous condition, alcoholism, drug addiction or other illness or organic weakness of a chronic or recurring nature? ☐ Yes ☐ No
If yes, please provide details:

____

____

24. Have you undergone or had any reason to undergo a surgical operation? ☐ Yes ☐ No
If yes, please provide details:

____

____

25. What accidents or illnesses have prevented you from attending to your business or occupation for periods of more than 14 days during the past three years?

____

____

26. Apart from any matter you have already described, are you now in and do you generally enjoy good health? ☐ Yes ☐ No
If no, please provide details:

____

____

27. Do you presently take any medications, over the counter or prescription medicine(s)? ☐ Yes ☐ No
If yes, please provide details:

____

____

28. What was your gross income less business expenses, but before taxes from your profession last year? US $_____________

29. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc? (Circle) US $_____________

30. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? US $_____________
Is this included in #28? ☐ Yes ☐ No

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DECLARATION

To the best of my/our knowledge and belief, the information provided in connection with this proposal, whether in my/our own hand or not, is true and I/we have not withheld any material facts. I/We understand that non-disclosure or misrepresentation of a material fact may entitle Underwriters to the insurance. (N.B. a material fact is one likely to influence acceptance or assessment of this proposal by Underwriters. If you are in any doubt as to whether a fact is material or not, you must disclose it.) I/We understand that Underwriters will determine their terms and conditions upon the information provided in connection with this proposal; and I/we further understand that the signing of this proposal does not bind me/us to complete or Underwriters to accept this Insurance.

A copy of full standard WORDING may be seen upon application to your broker.
If you would like a copy of this proposal form sent to you, please advise your broker.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I, the Proposed Insured, declare that all responses made to each and every question in the Application are truce and complete. I understand that:

Any false statements or material misrepresentations shall result in the loss of coverage under any policy and/or certificate which may be in force and/or any coverage which are being offered; and

No representation made to or information possessed by any agent shall be binding on the Underwriters and/or the Insurer, unless disclosed in the Application.

Signature of Proposed Insured ____________________ Printed Name ____________________

Signature of Policy Owner (*if not Proposed Insured*) ____________________ Printed Name ____________________

Date ____________________ Signed at (City, State) ____________________

Signature of Agent/Broker ____________________ Printed Name ____________________

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HIPAA Compliant Authorization for Release of Health Related Information

Name of Proposed Insured: Date of Birth:

First Middle Last mm/dd/yyyy

I authorize any health plan, physician, health care professional, Hospital, Clinic, Laboratory, pharmacy or pharmacy benefit manager, 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 me or my health, to give to International Specialty Insurance, any such information, to the extent permitted by law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or team trainer to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that International Specialty Insurance may: 1) work with underwriters to have the exclusions (if any) removed from my insurance policy; 2) conduct other legally permissible activities that relate to any coverage I have or have applied for with International Specialty Insurance.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand I have the right to revoke this authorization in writing, at any time, by providing written notification to International Specialty Insurance at 105 West Main Street, Elkin NC 28621. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me. I understand that any information that is disclosed is in pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by International Specialty Insurance except as authorized by me or as required by law.

I understand that International Specialty Insurance may not be able to process my application if I refuse to sign this Authorization. I further understand that if coverage has been issued, International Specialty Insurance may not be able to assist in removing medical exclusions placed on my insurance policy by underwriters or make any benefit payments. I understand that I or any authorized representative may receive a copy of this Authorization upon request.

Signature of Proposed Insured/Patient or Personal Representative Date

Signature of Witness Date

Please return completed forms to:
International Specialty Insurance
105 West Main Street
Elkin, NC 28621
336.835.2230 (p)
336.835.1729 (f)
www.isinsurance.com