INTERNATIONAL
SPECIALTY INSURANCE, INC

HELPING PROTECT WHAT YOU'VE ACHIEVED

QUESTIONS?
800-849-0474

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.

Buy-Sell Application Supplement

This application Supplement is part of the application(s) for insurance in the proposed insureds, as outlined in question 7 below.

1. Name of Business Entity: _____

2. Date Organized: ____ / ____ / ____ (MM / DD / YYYY)

3. Form of Business:

☐ C CORP ☐ S CORP ☐ PARTNERSHIP ☐ LLC ☐ LLP ☐ OTHER _____

4. Nature of Business:

_____

BRIEFLY DESCRIBE PRODUCT, SERVICE, ETC.

_____

5. Financial Data for Business Entity:	Last Full Year AS OF (DATE) _____	Previous Year AS OF (DATE) _____
A. Assets:	$	$
B. Liabilities:	$	$
C. Net Worth (Book Value):	$	$
D. Gross Income/Sales:	$	$
E. Net Profit (Loss):	$	$
F. Business Owners' Compensation from the Business Entity: INCLUDING BONUSES AND COMMISSIONS	$	$

6. What is your estimate of current fair market value of the business entity?

$ _____

_____

HOW WAS THIS DETERMINED?

7. Names of All Proposed Insured Business Owners	Age	Position OR TITLE	Compensation CURRENT ANNUAL TOTAL COMPENSATION FROM THIS BUSINESS	Percent PERCENT OF BUSINESS OWNED	Amount MONTHLY AMOUNT OF DISABILITY INCOME COVERAGE IN FORCE	OTHER DISABILITY BUY-OUT COVERAGE IN FORCE

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8. Is there a written disability buy-sell agreement in effect for this business entity? If yes, a copy of the agreement may be requested at the underwriter's discretion. ☐ YES ☐ NO

IF NO, PLEASE PROVIDE WHEN A DISABILITY BUY-SELL AGREEMENT BE EXECUTED

A BUY-SELL AGREEMENT MUST BE IN EFFECT WITHIN ONE YEAR AFTER THE EFFECTIVE DATE OF ANY DISABILITY BUY-OUT POLICY ISSUED.

9. Are all business owners of this business entity being insured for disability buy-out? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

10. Are there any familial relationships among the business owners? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

11. Are there other related business entities? ☐ YES ☐ NO

A. If Yes, are those entities included in the buy-sell agreement? ☐ YES ☐ NO

IF NOT INCLUDED IN THE BUY-SELL AGREEMENT, PLEASE EXPLAIN.

12. Do any proposed insured business owners have life insurance in force or applied for to fund a buy-out requirement at death? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

13. Do all proposed insured business owners work full-time in the business? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

14. Are all proposed insured business owners aware of the need for a formal disability buy-sell agreement that coincides with the provisions of the proposed coverage? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS:

15. Has the business entity experienced a net loss or a year-to-year increase in net profit, before income taxes, in any of the last five (5) years? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

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Buy-Sell Application Supplement

DECLARATION

I REPRESENT that all answers to the preceding questions are correctly recorded, and that they are true and complete to the best of my knowledge and belief. I agree that this application supplement shall become part of any contract of insurance based on such application.

Signature of Proposed Insured **Signed at** CITY STATE **Date** MM DD YYYY

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Signature of Proposed Insured **Signed at** CITY STATE **Date** MM DD YYYY

Signature of Proposed Insured **Signed at** CITY STATE **Date** MM DD YYYY

Signature of Policy Owner
IF OTHER THAN A PROPOSED INSURED **Signed at** CITY STATE **Date** MM DD YYYY

Title PRINT **Copy Name** PRINT

I declare and affirm that no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured(s) and owner (if other than proposed insured). If this form has been sent to International Specialty Insurance (ISI) electronically, the copy of this form sent to ISI is a true and exact copy of the original.

Producing Agent's Signature **Signed at** CITY STATE **Date** MM DD YYYY

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.

PLEASE RETURN COMPLETED FORMS TO:

INTERNATIONAL SPECIALTY INSURANCE
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Winston-Salem, NC 27103

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www.isinsurance.com