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.

AD&D Insurance Application

PART 1 - GENERAL

Proposed Insured:

FIRST NAME | M.I. | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

SOCIAL SECURITY NO.

Date of Birth:

MM | DD | YYYY

GENDER: ☐ MALE ☐ FEMALE

WEIGHT:

HEIGHT:

Occupation:

INSURED'S OCCUPATION

CURRENTLY FULL TIME? ☐ YES ☐ NO

NAME OF EMPLOYER | DUTIES AND DESCRIPTION OF OCCUPATION

ANNUAL EARNED INCOME | UNEARNED INCOME | NET WORTH

Is there any group or individual life / AD&D insurance applied for or in force on the proposed insured? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE COMPANY | POLICY NUMBER | AMOUNT | DATE ISSUED

Proposed Policy Owner/Beneficiary

NAME | RELATIONSHIP TO INSURED

OWNER'S ADDRESS | CITY | STATE | ZIP CODE

PART 2 - MEDICAL INFORMATION

1. Do you anticipate traveling overseas or participating in a hazardous sport or avocation during the terms of this policy? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS (I.E. LOCATION, DURATION, NATURE OF TRAVEL, OR TYPE OF ACTIVITY INVOLVED):

2. Will aviation travel be on regularly scheduled airlines? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS

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3. Have you ever had any life, health or accident insurance ever canceled or declined? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS

4. Have you any physical defect of infirmity? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

5. Is your sight or hearing defective? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

6. Have you ever suffered from high blood pressure, a heart condition, rheumatic fever, diabetes, spinal disorder, a hernia, or any rheumatic or arthritic condition? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS:

IT IS UNDERSTOOD AND AGREED AS FOLLOWS:

1. The above statements and answers are true, accurate and complete to the best of my knowledge and belief.

2. This application and any prior underwriting information shall form the basis of any insurance contract issued.

3. In some states we are required to inform you that: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of or insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which may be a crime, and in New York, shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

4. Except as amended by this application, any information provided on prior application for this coverage is expressly reaffirmed by me.

Signature of Proposed Insured **Date**

Signature of Proposed Owner (if other than Proposed Insured): **Date**

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AD&D Insurance Application

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, medical information service including Medical Information Bureau, Inc., urgent care facility, other medically related facility or entity, insurance or reinsurance, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition including drug or alcohol abuse, and/or treatment of me or my dependents and other non-medical information of me, to release to Underwriters at Lloyd's, London, and/or International Specialty Insurance Services, Inc., or its designee any and all such information. This authorization includes release of information concerning psychiatric/psychological conditions and preparation of an investigative consumer report.

I understand that the information obtained by use of the authorization will be used by Underwriters at Lloyd's, London, and/or International Specialty Insurance Services, Inc., to determine eligibility for insurance or to determine eligibility for benefits under the Policy. Any information obtained will not be released by the Insurer except to reinsuring companies, insurance support organizations or other person or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required.

I know that I may request to receive a copy of this authorization. I know that I may request to be interviewed if any investigative consumer report is prepared in connection with this application. I agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for twenty-six (26) months from the date signed.

Signature of Proposed Insured | **Date**

Signature of Proposed Owner (if other than Proposed Insured): | **Date**

Relationship:

AGENT STATEMENT

I certify that I have truly and accurately recorded all the information given to me by the applicant, and I certify that I know of no other medical information about the person applying for coverage other than that contained on this application. I certify that the applicant has either filled out the application or has personally reviewed the completed application. I have explained all policy benefits, exclusions and limitations.

Producing Agent's Signature | **Producing Agent's Name (please print)**

Date | **Agency Name**