Executives Application

Key Person Application

105 West Main St.
Elkin, NC 28621

800.849.0474 | 336.835.1729

ISI®

INTERNATIONAL SPECIALTY INSURANCE

International Specialty Insurance, Inc.
105 West Main Street
Elkin, NC 28621

Questions? Call 800.849.0474

"Helping protect what you've achieved"

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.

Please indicate the type of coverage you are applying for:

☐ Personal ☐ Buy-Sell ☐ Business Overhead Expense ☐ Key Person ☐ Loan Guarantee ☐ Other

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.

   Monthly Disability Benefits: $ _____ per month
   Permanent Total Disability: $ _____

10. If Monthly Disability Benefits are requested, please give the following details:
    a. the Elimination Period required: ☐ 30 days ☐ 60 days ☐ 90 days ☐ other _____
    b. the Maximum Benefit period required: _____ 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	aa.	Gall bladder	☐ Yes ☐ No
b.	Ears	☐ Yes ☐ No	bb.	Convulsions	☐ Yes ☐ No
c.	Nose	☐ Yes ☐ No	cc.	Concussions	☐ Yes ☐ No
d.	Cyst	☐ Yes ☐ No	dd.	Blood vessels	☐ Yes ☐ No
e.	Gout	☐ Yes ☐ No	ee.	Lymph nodes	☐ Yes ☐ No
f.	Knees	☐ Yes ☐ No	ff.	Intestinal tract	☐ Yes ☐ No
g.	Back/spine/neck	☐ Yes ☐ No	hh.	Urinary system	☐ Yes ☐ No
h.	Skin	☐ Yes ☐ No	ii.	Arthritis/joints /rheumatism	☐ Yes ☐ No
i.	Liver	☐ Yes ☐ No	jj.	Nervous system	☐ Yes ☐ No
j.	Heart	☐ Yes ☐ No	kk.	Growth/tumor	☐ Yes ☐ No
k.	Blood	☐ Yes ☐ No	ll.	Unconsciousness	☐ Yes ☐ No
l.	Bones	☐ Yes ☐ No	mm.	Circulatory system	☐ Yes ☐ No
m.	Throat	☐ Yes ☐ No	nn.	Fainting/dizziness	☐ Yes ☐ No
n.	Hernia	☐ Yes ☐ No	oo.	Paralysis/weakness	☐ Yes ☐ No
o.	Cancer	☐ Yes ☐ No	pp.	High blood pressure	☐ Yes ☐ No
p.	Bladder	☐ Yes ☐ No	qq.	Disorder of the brain	☐ Yes ☐ No
q.	Muscles	☐ Yes ☐ No	rr.	Lungs	☐ Yes ☐ No
r.	Kidneys	☐ Yes ☐ No	ss.	Asthma	☐ Yes ☐ No
s.	Glands	☐ Yes ☐ No	tt.	Allergies	☐ Yes ☐ No
t.	Thyroid	☐ Yes ☐ No	uu.	Tuberculosis	☐ Yes ☐ No
u.	Pancreas	☐ Yes ☐ No	vv.	Respiratory system	☐ Yes ☐ No
v.	Diabetes	☐ Yes ☐ No	ww.	Reproductive system	☐ Yes ☐ No
w.	Chest pain	☐ Yes ☐ No	xx.	Digestive system/stomach	☐ Yes ☐ No
x.	Headaches	☐ Yes ☐ No	yy.	Are you now pregnant?	☐ Yes ☐ No
y.	HIV/AIDS	☐ Yes ☐ No	zz.	Any condition not mentioned previously?	☐ Yes ☐ No
z.	Sleep apnea	☐ 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? ☐ Yes ☐ No
If yes, please provide details:

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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AUTHORIZATION

To all physicians, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other persons who have information about the proposed insured.

I authorize you to give the Insurer, its reinsurers, its agents all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the proposed insured and any non-medical information, including any investigative consumer reports, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the Proposed Insured is eligible for the insurance requested; or benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force.

The form will be valid for 36 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

Date (month/day/year)

Signature of Proposed Insured

Printed Name of Proposed Insured

Please return completed forms to:

International Specialty Insurance
105 West Main Street
Elkin, NC 28621
336.835.2230
336.835.1729 (f)
www.isinsurance.com

Submit by Email | Print Form