ASCE | MEMBER INSURANCE

CATASTROPHIC DISABILITY INCOME INSURANCE APPLICATION

Underwritten by:
Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828
Portland, Maine 04112-8828
Group Policy Number: 1158

To Apply: Please complete this form and return to:
ASCE Member Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348
Questions: Please call 1.800.650.2723

Trustees of the American Society of Civil Engineers Group Insurance Trust

CATASTROPHIC DISABILITY INCOME INSURANCE APPLICATION

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.

PART I Personal Info

1A. Member Information:

Full Name _____
Last First Middle Initial

Home Street Address _____

City _____ State (or Province) _____ Zip Code ☐☐☐☐☐-☐☐☐☐

Billing Address _____

Daytime Phone (_____) _____ E-mail _____
For internal use only. E-mail address will never be sold or shared.

Social Security #: ☐☐☐-☐☐-☐☐☐☐ Sex: ☐ Male ☐ Female

Date of Birth: ____ /____/____ Except MD residents Place of Birth: _____ Citizenship/Country:_____

Beneficiary: _____ Relationship of Beneficiary to you: _____

Application is made for: ☐ New Coverage
☐ Increase / Certificate No.: _____ Current Amount of Coverage: $_____
☐ Reinstatement / Certificate No.: _____ Amount of Coverage: $_____

1B. Membership Affiliation—Occupational Status:

a. Are you now a member of the ASCE? ☐ Yes ☐ No (Association Membership is required for participation in this plan.)
ASCE Membership #_____ Exp. Date: _____

b. What is your occupation? _____ How many hours a week do you work? _____

c. Main duties _____

PART II Your Coverage

2. Plan Selection: Catastrophic Disability Coverage.

A. MAXIMUM MONTHLY BENEFIT (Member coverage only): $_____ ($1,000 to $10,000 per month, in increments of $100, not to exceed 100% of your Annualized Monthly Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.)

B. MAXIMUM BENEFIT PERIOD (Select one): ☐ 60 Months ☐ 120 Months ☐ To Age 65

C. ELIMINATION PERIOD (Select one): ☐ 60 days ☐ 90 days ☐ 180 days ☐ 360 days

D. OPTIONAL BENEFIT: ☐ Extended Catastrophic Disability Benefit (Choose an amount between $10,000 to $100,000):
☐ Member Only: _____ ☐ Member and Spouse: _____ (Complete Spouse Information below.)
Spouse Information: Name of Spouse: _____ Date of Birth: ____/____/____
Place of Birth: _____ Citizenship/Country: _____

Be Sure To Complete All Pages and Sign Last Page

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?	Who is insured by Other Coverage?
					☐Yes ☐No	☐Yes ☐No	☐Member ☐Spouse
					☐Yes ☐No	☐Yes ☐No	☐Member ☐Spouse
					☐Yes ☐No	☐Yes ☐No	☐Member ☐Spouse
					☐Yes ☐No	☐Yes ☐No	☐Member ☐Spouse

4. Financial Information:

A. Business Type (check one): ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Partnership ☐ Limited Liability Corporation ☐ S-Corporation ☐ Other (specify): _____

B. Percentage of business owned by you: _____ Number of years owned by you: _____
Number of years business has been in existence: _____

C. 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 $ _____

5. Member's/Spouse's Statement of Health:

PART III Your Health

Member:

a. Height: ___ft. ___in. Weight: _____lbs. Weight change last year: _____ lbs. Reason for weight change: (Gain or Loss)
b. Name of Personal Physician (If none, please indicate): _____
Physician Address:_____
Date Last Seen: ___/___/___ Reason:_____ Results:_____

Spouse:

a. Height: ___ft. ___in. Weight: _____lbs. Weight change last year: _____ lbs. Reason for weight change: (Gain or Loss)
b. Name of Personal Physician (If none, please indicate): _____
Physician Address:_____
Date Last Seen: ___/___/___ Reason:_____ Results:_____

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
1. 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?	☐	☐	☐	☐
b) been homebound or hospitalized because of sickness or injury?	☐	☐	☐	☐
Member: If Yes to (a) or (b), for how many days? _____ Date(s):_____ Reason:_____				
Spouse: If Yes to (a) or (b), for how many days? _____ Date(s):_____ Reason:_____				
2. 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?	☐	☐	☐	☐
3. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN), have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? In MN, indicate Yes/No for deep sea diving, parachuting/paragliding, rock/mountain climbing, or organized motorized speed racing	☐	☐	☐	☐

continued...

Be Sure To Complete All Pages and Sign Last Page

5. Member's/Spouse's Statement of Health continued:

	MEMBER		SPOUSE	
	YES	**NO**	**YES**	**NO**
4. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN), 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 and MN , 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?	☐	☐	☐	☐
b. shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities, or any disease or disorder of the lung?	☐	☐	☐	☐
c. diabetes, any glandular, thyroid, or other endocrine disease or disorder?	☐	☐	☐	☐
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?	☐	☐	☐	☐
e. depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease?	☐	☐	☐	☐
f. cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia, or immune system? (In ME and WI, excluding HIV)	☐	☐	☐	☐
g. liver, digestive system, either kidney, urinary, or reproductive tract, prostate, or sexually transmitted diseases (Except for HIV)?	☐	☐	☐	☐
h. dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease?	☐	☐	☐	☐
i. loss of hearing or vision, or disease or disorder of the eyes, ears, nose, or throat?	☐	☐	☐	☐
j. chronic fatigue, Epstein Barr virus, fibromyalgia?	☐	☐	☐	☐
k. complications of pregnancy? l. Are you pregnant? If "yes," due date:____/____/____	☐	☐	☐	☐
5. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME and WI, excluding HIV)	☐	☐	☐	☐
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.)				
6. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN), 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)	☐	☐	☐	☐
7. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN), 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)	☐	☐	☐	☐
8. 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?	☐	☐	☐	☐
9. During the past 10 years (7 years in MD; 5 years in IN, KS, and MN) have you:				
a. sought, been advised to seek, or received treatment for the use of alcohol, or (except in NC) received counseling for the use of alcohol?	☐	☐	☐	☐
b. used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received treatment for the use of prescribed or non-prescribed drugs; or (except in NC) received counseling for the use of prescribed or non-prescribed drugs; or been arrested for the possession of or use of prescribed or non-prescribed drugs?	☐	☐	☐	☐
c. to the best of your knowledge and belief, been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)or AIDS Related Complex (ARC); or, except for residents of Florida, been treated for AIDS or ARC? (in ME, excluding HIV).	☐	☐	☐	☐
10. **[If you are a resident of CA, CO, CT, ME, ND, NJ, NY or WI do not answer question 10.]** During the past 10 years (7 years in MD, 5 years in IN, KS, and MN) have you tested positive for the presence of the Human Immunodeficiency Virus ("HIV") or HIV antibodies?	☐	☐	☐	☐
11. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet, or transferring?	☐	☐	☐	☐
12. During the past 10 years (7 years in MD, 5 years in IN, KS, and MN) have you used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb	☐	☐	☐	☐
13. During the past 10 years (7 years MD, 5 years in IN, KS, and MN) have you had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application?(In ME, excluding HIV)	☐	☐	☐	☐

Medical Details (Please provide details if you answered "YES" to any item in the Member/Spouse Statement of Health Section.) If you need more space, attach separate sheet with additional information.

Question Letter/No.	Member or Spouse	Reason/ Condition	Diagnosis/Treatment/ Results	Name, Address & Phone # of Physician and/or Hospital	Date of Onset	Date Last Seen	# of Days Lost from Work

Be Sure To Complete All Pages and Sign Last Page

Fraud Notice:The following Notice applies to residents of FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **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, 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 RI:** 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. **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: Collection of Information (applies to residents of New Jersey only)** This application is our main source of information. But we may also ask you to have a physical exam, an EKG and/or a blood profile, etc; ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us; obtain information from the Medical Information Bureau (MIB); seek information from other companies you have applied to for insurance; seek information about you from public records. If we require any additional information, we will seek your permission prior to obtaining it through use of a written request.

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 understand that any pre-existing condition (including any injury, sickness, mental illness, or substance abuse) for which: (a) I was diagnosed or received treatment from a physician or other licensed practitioner of the healing arts; or (b) I took any drugs or medications within the 6 month period prior to my effective date of insurance, will not be covered until the earlier of: (1) the date I have been insured under the policy for 12 months after my Effective Date; or (2) the date I have been free of treatment for such condition for a one-year period ending on or after my Effective Date. Except in ID, ME, and MO, I further understand that pre-existing conditions include any symptoms or subjective symptoms that I had within the 3 month period prior to my Effective Date.

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.

The following applies only to Oklahoma residents and is in lieu of the preceding paragraph: 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.

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.

PART IV Your Signature(s)

Member's Signature **X**_____ Date **X**_____

Spouse's Signature **X**_____ Date **X**_____

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.

In Minnesota, this authorization excludes information on blood borne pathogens and HIV antibody tests if performed: on criminal offenders or their victims as the result of a crime reported to police; or on any person giving or receiving emergency care including the patient, emergency medical, fire, or police personnel, or any person qualifying for this exemption under Minnesota law, including the Good Samaritan law.

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

Be Sure To Complete All Pages and Sign Last Page

Form No: ADI-4001-APPA / In VA: ADI-4001-APPV2VA Rev. 12-15-2016 1158

160157-ASCE-CDI-GEN