Disability Income Application—Virginia State Bar

To apply, please answer the following questions:

- Are you presently a member of The Virginia State Bar? ☐ Yes ☐ No
- Select coverage desired:
  Monthly Income Benefit: $________ *(May elect $500 to $10,000 in multiples of $100, subject to the restrictions in item 3 below.)*
- Benefit Period *(Check one.)*: ☐ Plan A—Payments up to 2 years ☐ Plan B—Payments up to 5 years ☐ Plan C—Payments up to age 65
- Qualifying Period *(Check one.)*: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 6 months ☐ 12 months
- Cost of Living Adjustment (COLA): ☐ Yes ☐ No (available only with Plan B or Plan C Benefit Period)
- Payment method: ☐ Semi-annual

Complete, date and sign form below. Mail to: Virginia State Bar Members' Insurance Center
9954 Mayland Drive,Suite 2200
Richmond, VA 23233

Send no money now. Once accepted, you will receive a billing notice with your Certificate of Insurance.
Application I hereby apply to the Union Security Insurance Company for Disability Income Insurance based on the following statements.

1.

Applicant's name *(last, first, middle)*	Sex ☐ M ☐ F	Age	Date of Birth Mo./Day/ Year	Height (Ft., In.)	Weight (Lbs.)
Street address		City		State	Zip
Mailing address		City		State	Zip
Business phone	Home phone		Applicant's Social Security number		

2. Are you working 25 hours per week in the duties of your profession? ☐ Yes ☐ No (If "No," please provide details below.)
3. The elected Monthly Income Benefit may not exceed an amount which, in combination with benefits payable under all other disability income contracts issued or applied for, exceeds 66 2/3% of your current monthly earnings.*

   * For lawyers who are not partners, monthly earnings are defined as a 3 year average of the insured's monthly rate of earnings (excluding commissions). Partnership earnings are defined as an average of the prior 3 years ordinary income as reported on Schedule K-1 Partnership Return Income Form 1065, excluding amounts derived from return of capital, interest or dividends.

   What are your current monthly earnings? $________

   Has any other accident or sickness disability insurance been issued to or applied for by you? ☐ Yes ☐ No

   If "Yes," give details including durations for which benefits are payable, the amounts of monthly benefit and, if applicable, the names of employers or associations through which insurance is provided ________
4. Has any application for insurance ever made by you been postponed, declined, rated up or modified? ☐ Yes ☐ No
   If "Yes," reason? ________
5. To the best of your knowledge and belief, have you ever had, been treated for, or told you had:
   a. Heart disease, high blood pressure, varicose veins, or disease of or dysfunction of the circulatory system? ☐ Yes ☐ No
   b. Diabetes, goiter or any disease of or dysfunction of the glands? ☐ Yes ☐ No
   c. Epilepsy, fainting attacks, mental disorder, or other disease of or dysfunction of the brain or nervous system? ☐ Yes ☐ No
   d. Fistula, fissure, hemorrhoids or other disease of or dysfunction of the rectum? ☐ Yes ☐ No
   e. Cancer or tumor, syphillis or tuberculosis? ☐ Yes ☐ No
   f. Asthma, pleurisy, or other disease of or dysfunction of the respiratory tract? ☐ Yes ☐ No
   g. Neck or back strain or injury or hernia? ☐ Yes ☐ No
   h. Any deformity or loss of limb? ☐ Yes ☐ No

i. Any disease of or dysfunction of the reproductive organs? ☐ Yes ☐ No
j. Ulcer or any disease of or dysfunction of the stomach, intestines, liver, gall bladder, or other disease of or dysfunction of the gastrointestinal tract? ☐ Yes ☐ No
k. Sugar in urine, kidney disease, or other disease of or dysfunction of the genitourinary tract? ☐ Yes ☐ No
l. Arthritis, rheumatism, or other disease of or dysfunction of the bones? ☐ Yes ☐ No
m. Any impairment of sight, speech or hearing, or any disease of or dysfunction of the eye, ear, nose or throat? ☐ Yes ☐ No
n. Any surgical operation performed or been advised to have any surgery performed during the past five years? ☐ Yes ☐ No
o. Any alcoholic and/or drug addiction and/or abuse? ☐ Yes ☐ No
p. AIDS or immunodeficiency disease? ☐ Yes ☐ No

6. Have you had any medical advice, examination, consultation or treatment during the past five years, not mentioned in question number 5? If "Yes," please state details in the block portion below. ☐ Yes ☐ No

7. If you answered "Yes" to any part of question numbers 5 or 6, please complete the following:

Give details to all "Yes" answers. If more space is needed attach separate sheet.					
Question Number	Name of Condition	Date Occurred	Duration	Degree of Recovery	Names and Addresses of Physicians, Hospitals or Clinics Consulted

8. Are you currently using any kind of medically prescribed medication? ☐ Yes ☐ No If "Yes," indicate name of medication and medical condition. ______________________________

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9. Name and address of family physician ______________________________

____
STREET NO. AND NAME CITY STATE ZIP CODE

I understand that if on the effective date of coverage, I am not actively at work on the date I would otherwise become insured, insurance will become effective on the first day I return to active work.

Is this replacing existing insurance? ☐ Yes ☐ No The undersigned applicant has read, or had read to him, the completed application and the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

AUTHORIZATION TO OBTAIN UNDERWRITING INFORMATION

I hereby (1) certify that the above dates of birth, heights and weights are correct and that I do presently work the number of hours per week stated above, (2) certify that any and all information disclosed on the enrollment application is accurate and that my answers to the foregoing medical questions (5 through 8) and any statements relating to these questions are true and complete, and that every occasion and instance as to each item answered "Yes" has been disclosed, and (3) certify that I have read, or had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any knowledge of me, or that has attended, or who will hereafter attend me, to give the Union Security Insurance Company any such information. I have read, understood, and retained a copy of the Notice Regarding Medical Information Bureau. A photostatic copy of this authorization shall be as valid as the original.

I know that I and any authorized representative have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. For claim purposes, this authorization will remain valid for the term of the coverage of the policy if health insurance or the duration of the claim for non-health insurance. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorizaiton form, allowing Union Security Insurance Company to use and disclose protected health information.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Signature of Applicant ______________________________ Date ______________

NOTICE REGARDING MEDICAL INFORMATION BUREAU
INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

In addition, we may obtain an investigative consumer report from an insurance support organization. If a report is prepared, upon request to your agent, you have the right to be personally interviewed in connection with the investigation. Also, upon proper request to Union Security Insurance Company, you may obtain a copy of the report.

Further, we or our reinsurers may obtain a report from and make a report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member for life or health coverage, or a claim is submitted to such a company, the bureau, upon request, will supply information contained in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of the information in its file. If the accuracy of the information is questioned, you may request that corrections be made following the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, MA 02112 (telephone 617.426.3660).

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding.

If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Executive Vice-President, Group Operations, 2323 Grand Boulevard, Kansas City, Missouri 64108.