



**POLICY INFORMATION - to be completed by agent**

**CHECK COVERAGE DESIRED**

Occupation Class \_\_\_\_\_  
 Industry Code \_\_\_\_\_  
 Industry Class A B C D E

Coverage	Number of Units*	Accident Elimination Period	Sickness Elimination Period	Disability Benefit Period	Modal Premium	
<input type="checkbox"/> Base Short-Term Disability Policy	_____	<input type="checkbox"/> 0 Days	_____	<input type="checkbox"/> 7 Days	<input type="checkbox"/> 3 months	\$ _____
				<input type="checkbox"/> 14 Days	<input type="checkbox"/> 6 months	
		<input type="checkbox"/> 7 Days	<input type="checkbox"/> 14 Days	<input type="checkbox"/> 18 months	<input type="checkbox"/> 12 months	
				<input type="checkbox"/> 24 months	<input type="checkbox"/> 18 months	
		<input type="checkbox"/> 14 Days	<input type="checkbox"/> 14 Days	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 24 months	
				<input type="checkbox"/> 60 Days	<input type="checkbox"/> 6 months	
		<input type="checkbox"/> 30 Days	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 90 Days	<input type="checkbox"/> 12 months	
				<input type="checkbox"/> 180 Days	<input type="checkbox"/> 18 months	
<input type="checkbox"/> 60 Days	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 24 months	<input type="checkbox"/> 24 months			
<input type="checkbox"/> 90 Days	<input type="checkbox"/> 90 Days	<input type="checkbox"/> 12 months	<input type="checkbox"/> 18 months			
<input type="checkbox"/> 180 Days	<input type="checkbox"/> 180 Days	<input type="checkbox"/> 12 months	<input type="checkbox"/> 18 months			
<input type="checkbox"/> 24 months		<input type="checkbox"/> 12 months	<input type="checkbox"/> 18 months			
<input type="checkbox"/> On the Job Accident Disability Rider		<i>Same as Base Policy</i>			\$	
<input type="checkbox"/> Spouse Off the Job Accident Disability Rider		0 Days	n/a	6 months	\$	
<b>*NOTE: Each unit is equal to a \$100 monthly benefit</b>					\$	

**DISABILITY COVERAGE INFORMATION – Please complete 1 – 2a**

1. Is any person proposed to be insured covered under another short term disability policy with:
- |                                           |                             |                                              |                                                          |
|-------------------------------------------|-----------------------------|----------------------------------------------|----------------------------------------------------------|
| - Time Insurance Company .....            | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | Is this a change of that coverage?                       |
| - Union Security Insurance Company .....  | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| - John Alden Life Insurance Company ..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes, policy # _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes |
- 2a. I certify that my **gross annual income** (without overtime, unless contractual, bonuses or other incentives) for my full-time job is ..... \$ \_\_\_\_\_  
 (If you are self-employed, your gross annual income is your net earnings.)  
 I understand this information will be verified at the time of the claim.  
**Annual income must be \$10,000 or greater for coverage to be issued.**

**ON THE JOB ACCIDENT DISABILITY RIDER – Complete 2b only if applying for the rider coverage.**

- 2b. Are you covered by Workers' Compensation or a similar coverage in your full-time job? .....  Yes  No

**If you answered "Yes" to 2b, you are not eligible for ON THE JOB DISABILITY coverage; therefore the rider will not be issued.**

**SPOUSE OFF THE JOB ACCIDENT DISABILITY BENEFIT RIDER – Complete 2c only if applying for the rider coverage.**

- 2c. I certify that my spouse's gross annual income (without overtime, unless contractual, bonuses or other incentives) for his/her full-time job is ..... \$ \_\_\_\_\_  
 I understand this information will be verified at the time of the claim.
- Spouse's Employer \_\_\_\_\_
- Spouse's Job Duties \_\_\_\_\_

**DISABILITY COVERAGE INFORMATION – Complete 3 – 15 for the Applicant; complete the Spouse response only if applying for the Spouse Off the Job Accident Disability Benefit Rider noted above .**

	<b>Applicant</b>	<b>Applicant's Spouse</b>
3. If your industry is class E, have you been employed for <b>less than 12 months</b> with the employer listed on the front of this application? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	n/a
4. Do you currently have disability coverage, which remains in force, and if combined with this applied-for coverage, will exceed 70% of your monthly gross (pre-tax) income? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you work fewer than thirty (30) hours per week in your primary (full-time) occupation with the employer listed on this application? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been charged with driving under the influence of alcohol or any narcotic within the last twelve (12) months or been charged two or more times within the last five (5) years? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you currently on leave or not working because of sickness, maternity or injury? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you unable to perform any material or substantial duties of your job because of sickness, maternity or injury? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<u>Applicant</u>	<u>Applicant's Spouse</u>
9. Have you ever been diagnosed with or ever treated for any of the following: .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• Cardiomyopathy</li> <li>• Chronic fatigue syndrome</li> <li>• Chronic hepatitis</li> <li>• Chronic liver disease</li> <li>• Chronic obstructive pulmonary disease</li> <li>• Crohn's disease</li> <li>• Emphysema</li> </ul>	<ul style="list-style-type: none"> <li>• Fibromyalgia</li> <li>• Heart valve replacement</li> <li>• Multiple sclerosis</li> <li>• Muscular dystrophy</li> <li>• Psoriatic arthritis</li> <li>• Pulmonary fibrosis</li> <li>• Regional enteritis / ileitis</li> </ul>	<ul style="list-style-type: none"> <li>• Rheumatic fever</li> <li>• Rheumatoid arthritis</li> <li>• Stroke or TIA (mini-stroke)</li> <li>• Systemic lupus</li> <li>• Ulcerative colitis</li> <li>• Vascular insufficiency (circulatory problems)</li> </ul>
10. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) or tested positive for human immunodeficiency virus (HIV)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>Acquired Immune Deficiency (AIDS) is caused by a virus known by several names i.e. Human Immunodeficiency Virus (HIV); Human T-Lymphotropic Virus Type III (HTLV-III); Lymphadenopathy Associated Virus (LAV); and AIDS Related Virus (ARV). It may take anywhere from a few months to several years or more after initial infection with HIV for AIDS or ARC to develop. AIDS is a condition that breaks down part of the body's immune system making it difficult for the body to fight off infection and disease. AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorder with no known cause.</i></p>		
11. In the past five years, have you been diagnosed or treated for cancer (other than non-melanoma skin cancers)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been diagnosed with or received treatment for Type I diabetes; or Type II diabetes (1) diagnosed prior to age 30, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use or (4) requiring the use of insulin within the past five years? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. In the past 24 months, have you ever been diagnosed with or had surgery for any of the following: .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• Angina (heart-related chest pains)</li> <li>• Atrial fibrillation</li> <li>• Carpal tunnel syndrome</li> </ul>	<ul style="list-style-type: none"> <li>• Congestive heart failure</li> <li>• Coronary angioplasty (or stents)</li> <li>• Coronary bypass surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Drug or alcohol abuse</li> <li>• Heart attack</li> <li>• Kidney disease (not including kidney stones)</li> <li>• Sciatica</li> </ul>
14. In the past 12 months, have you received treatment in an emergency room or hospital or missed ten total days of work for any of the following for which symptoms existed: .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>• Asthma</li> <li>• Blood disorders</li> <li>• Chronic bronchitis</li> </ul>	<ul style="list-style-type: none"> <li>• Diverticulitis</li> <li>• Gastric bypass</li> <li>• Hypertension / high blood pressure</li> </ul>	<ul style="list-style-type: none"> <li>• Joint replacement</li> <li>• Pancreatitis</li> <li>• Seizures</li> <li>• Type II diabetes</li> </ul>
15. Have you been advised by a physician to be hospitalized or to have surgery that has not yet been performed (excluding routine childbirth)? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If any responses to 3 – 15 for the Applicant are “Yes”, a policy will not be issued; therefore, do not submit this application. If all responses are “No”, continue with 16 – 21.**

**If any responses to 4 – 15 for the Spouse are “Yes”, the Spouse Off the Job Disability Benefits Rider will not be issued; no spouse coverage will be provided. If all responses are “No”, continue with 16 – 21.**

- |                                                                                                                                                                                                     | <b>Applicant</b>                                         | <b>Applicant's Spouse</b>                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| 16. Have you received disability benefits or claimed Workers' Compensation in the last five years? .....                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. In the past 12 months, have you missed five consecutive days or ten total days of work because of your sickness or injury (not related to routine childbirth) for which symptoms existed? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. In the past 12 months, have you been confined in a hospital as an inpatient (not including confinement because of routine childbirth)? .....                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. In the past 12 months, have you been diagnosed or treated for an injury, sickness, or disorder of the back, the neck, or a joint, for which symptoms existed? .....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. In the past 12 months, have you been diagnosed or treated for any heart disease or disorder for which symptoms existed, excluding insignificant heart murmurs? .....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Are you applying for the 24-month benefit period or for more than 20 units in any one of the monthly disability benefits? .....                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | n/a                                                      |
- (See POLICY INFORMATION on page 1 for your selections)**

**If any responses to 16 – 21 are “Yes”, please complete 22; otherwise continue to the next item.**

22. Within the last six weeks, have you been prescribed any medication or taken any prescription medication (not including prescription contraceptives)?.....
- Yes  No       Yes  No
- If “Yes”, please provide complete information below.**

Medication Name	Dosage	Frequency	Date First Prescribed	Reason	Prescription is for:	
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
					<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse

**If your response to 21 is “Yes”, please complete 23 and 24; otherwise continue to the next item.**

23. During the past 24 months, excluding routine checkups, have you been treated for any other sickness / injury or have you had any medical / surgical treatment, other than those already noted in this application? .....
- Yes  No      n/a
24. Do you have any group disability income coverage in force? .....
- Yes  No      n/a
- If “Yes”, list the monthly benefit amounts / percentages: \_\_\_\_\_
- If “Yes”, list the Benefit Period: \_\_\_\_\_
- If “Yes”, list the Elimination Period: \_\_\_\_\_

If any **Applicant** responses to 16 – 20 or 23 are “Yes”, please complete 25a; otherwise continue to the next item.

25a. Applicant’s Physician’s Name \_\_\_\_\_ Phone Number (     )  
If no regular physician, then physician last seen  
 Address \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP  
 Date last seen by Physician \_\_\_\_\_ Reason for last visit \_\_\_\_\_

	Medical Condition	Onset (mo./yr.)	Surgery Performed? (if “Yes, provide type of procedure and date)
#16 Detail:			
#17 Detail:			
#18 Detail:			
#19 Detail:			
#20 Detail:			
#23 Detail:			

If any **Spouse** responses to 16 – 20 or 23 are “Yes”, please complete 25b; otherwise continue to the next item.

25a. Applicant’s Physician’s Name \_\_\_\_\_ Phone Number (     )  
If no regular physician, then physician last seen  
 Address \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP  
 Date last seen by Physician \_\_\_\_\_ Reason for last visit \_\_\_\_\_

	Medical Condition	Onset (mo./yr.)	Surgery Performed? (if “Yes, provide type of procedure and date)
#16 Detail:			
#17 Detail:			
#18 Detail:			
#19 Detail:			
#20 Detail:			

## PROPOSED POLICYOWNER'S AGREEMENT

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:

The policy, if approved by Time Insurance Company, will have the Effective Date recorded on the Policy Schedule by Time Insurance Company. I acknowledge receiving the following, if required:

- Fair Credit Reporting Act Pre-Notification
- Outline of Coverage (if required by state law)
- the Abbreviated Notice of Insurance Information Practices
- the notification regarding the Medical Information Bureau

I understand that the premium amount listed on this application represents the premium amount that my employer will remit on my behalf if I select payroll deduction as the method of premium payment. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided and any other pertinent information that may be required for proper underwriting. The answers are complete and true to the best of my knowledge and belief. I understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions in the policy.

- A.M.
- P.M.

\_\_\_\_\_  
Signature of proposed Policyowner

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Time Signed

\_\_\_\_\_  
City & State

## AGENT INFORMATION AND REVIEW

Agency Name and Time Agency Number \_\_\_\_\_

Agent Name and Time Agent Number \_\_\_\_\_

Agent Phone Number ( ) \_\_\_\_\_

Agent Fax Number ( ) \_\_\_\_\_

General Agent is located in the state of \_\_\_\_\_

I certify that:

- I personally saw the applicant. The applicant was asked each required question and the answer truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.
- The application was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

\_\_\_\_\_  
Licensed Resident Agent's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Initial here if you witnessed the signing of this form by the proposed Policyowner.

## **FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION**

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

## **ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, PO Box 1739, Ft. Mill, SC 29716-1739.

## **FRAUD WARNING**

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.

## **NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon 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 company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction on accordance with the procedures set forth in the federal fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.