TDIC Insurance Solutions Application for CDA-endorsed Business Overhead Expense Insurance

TDIC Insurance Solutions
1201 K Street, Sacramento, CA 95814
800.733.0633 tdicsolutions.com

Underwritten by **The United States Life Insurance Company** in the City of New York, (Herein called the Company)
Home Office: One World Financial Center, 200 Liberty Street, New York, New York 10281
TDIC CA License Number: 0652783

Please neatly print or type all answers to the questions asked. Answer all questions completely to avoid unnecessary correspondence. Use a separate sheet of paper if necessary.

1. Applicant's name (first, middle, last): ______
2. Association: *California Dental Association* ______ ______
3. Occupation: *Dentistry* ______
4. Applicant's address (street, city, state, zip): ______
5. Name & address of applicant's physician: ______
6. Work phone: ______ 7. E-mail address: ______
8. Home phone: ______ 9. Work fax: ______
10. Personal data:

Gender	Age	Date of birth MM/DD/YR	Place of birth	Height Ft.	Height In.	Weight / lbs.
☐ M ☐ F						

11. Are you now, and have you been for the last 30 days, performing all the duties of your regular occupation for at least 20 hours per week for your present employer? ☐ Yes ☐ No
12. Annual earned income (after business expenses): $______ 13. Date of hire: ______
14. Business address: ______

Insurance Requested *(All policy applications that are approved will have a 30 day waiting period and a maximum benefit period of 24 months.)*

15. Is this a new request, or an increase to your existing benefit? ☐ New ☐ Increase
16. Monthly benefit requested: $______ *($500 to $25,000 in increments of $100 and not to exceed the monthly expense you actually incurred)*
17. Your share of the eligible expenses is: $ ______

Health Information

18. Please answer these brief questions to the best of your knowledge and belief. Have you ever had or been treated for (circle the specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack?	☐ Yes ☐ No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder?	☐ Yes ☐ No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder?	☐ Yes ☐ No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast?	☐ Yes ☐ No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	☐ Yes ☐ No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders?	☐ Yes ☐ No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	☐ Yes ☐ No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?	☐ Yes ☐ No
e. Disease or disorder of the rectum? Vascular or blood disorder?	☐ Yes ☐ No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor?	☐ Yes ☐ No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?	☐ Yes ☐ No	m. A surgical operation? Or a surgical operation advised but not performed?	☐ Yes ☐ No
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine?	☐ Yes ☐ No	n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system?	☐ Yes ☐ No
		o. Alcohol or drug abuse?	☐ Yes ☐ No

Please complete and sign application on page 2

19. Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated on page 1 of this application? ☐ Yes ☐ No

20. Are you now taking prescription medication or receiving medical attention? ☐ Yes ☐ No

21. For "Yes" answers to questions 18-20, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" ☐ Yes ☐ No

Question #	Condition	Date occurred	Duration	Degree of recovery	Name & address of physician, hospitals or clinics consulted

Existing and Pending Insurance Section

22. Do you have any Business Overhead Insurance in force or pending? (including group coverage). ☐ Yes ☐ No

23. If "Yes" to question 22, please indicate companies and amounts: ______________________________

24. Will this coverage applied for replace any insurance now in force? ☐ Yes ☐ No

25. If "Yes" to question 24, please indicate which insurance and the amount being replaced: ______________________

Authorization and Declaration of Each Person Giving a Statement of Insurability

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

All premium payments will be billed quarterly.

A copy of this application will be attached to and made a part of your certificate.

Date: ____________________ Applicant's signature ______________________________________

G-19464 CA AG-10781

Applicant should be sure to detach and retain the notices on page 3.

Please return this signed and completed application today!

Fax application to: 916.498.6104

or mail to: Attention: New Business Team
TDIC Insurance Solutions
1201 K St. 17th Floor
Sacramento, CA 95814

These Notices must be detached and retained by the applicant

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

Notice as Required Under the Fair Credit Reporting Act(s)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.