



# Exclusively for ISMS and CMS Members...

## Business Overhead Expense Application for Insurance



PBT Insurance Office  
300 South Wacker Dr., Suite 700  
Chicago, IL 60606  
Ph: 1-800-621-0748 • Fax: 1-312-922-2849

Hartford Life Insurance Company,  
Simsbury, Connecticut  
Physicians' Benefits Trust  
Policy Number AGP-5078

Applicant's Name: \_\_\_\_\_ Sex:  M  F Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.  
*(First, Middle Initial, Last)*

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Place of Birth (Town, State) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is your membership with sponsoring association group active?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Duties: \_\_\_\_\_ Average Monthly Earnings \$ \_\_\_\_\_

COVERAGE REQUESTED:  New Coverage: Monthly Benefit Amount: \$ \_\_\_\_\_

<b>BUSINESS OVERHEAD EXPENSE INSURANCE</b>	Monthly Benefit Desired: \$ _____ (\$500 up to \$7,500 in \$100 increments) (This figure should be based on actual overhead expenses) <input type="checkbox"/> 30 Day Waiting Period <input type="checkbox"/> 60 Day Waiting Period Average office overhead expenses incurred over the past 6 months: \$ _____ Maximum Benefit Period: 24 months (Disabilities occurring on or after age 64 will have a 12 month maximum.)
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PLEASE BILL ME (Send No Money Now)  Quarterly  Semi Annual  Annual

1. **OTHER INSURANCE INFORMATION:** Do you have any Disability Income Insurance in force or pending in this or any other company?  Yes  No

Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Have you been actively engaged in full-time duties of your occupation during the 90 day period immediately before the date of this application?  Yes  No

**PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:**

3. Have you ever been diagnosed or treated by a member of the medical profession for:
- A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?  Yes  No
  - B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?  Yes  No
  - C. Colitis, ulcer, kidney disease or disorder of the digestive, urinary or reproductive system?  Yes  No
  - D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disorder of the brain or nervous system including mental or emotional disorders?  Yes  No
  - E. Cancer, tumor, diabetes, blood or sugar in the urine, or any disease or disorder of the glands?  Yes  No
  - F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?  Yes  No
  - G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)\*?  Yes  No

4. During the past 5 years have you consulted any physician, surgeon, psychologist, psychiatrist or other medical or dental practitioner for anything other than a routine physical, eye examination or dental examination for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?  Yes  No

5. Are you now pregnant?  
 If yes, when is the baby due? \_\_\_\_\_  
 Are there any medical complications?  Yes  No

\*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 disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

If you answered "Yes" to any of the above questions, please explain the details. Explain nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery.

Question Number	Name	Disorder or Reason	Dates To/From	Details

**AUTHORIZATION**

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by the Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer; to give The Hartford or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status.

The Hartford will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, [underwriting coverage applied for] or administering coverage issued as a result of this application or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices.

I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until two (2) years after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

**STATE NOTICE**  
Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person 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, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by law.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_