



PLEASE CHECK REASON FOR COMPLETING:  INITIAL APPLICATION  INCREASE

**APPLICANT'S INFORMATION:**

<b>Name</b> (Last, First, Middle Initial)		Sex	Birthdate	Social Security #	Height	Weight	Place of Birth (State)
		<input type="checkbox"/> M <input type="checkbox"/> F					
Occupation / Job Title			Hrs. Worked / Week		Annual Earned Income		
Employer Name:			E-mail Address:				
Applicant's Street Address			City		State	Zip	
Business Phone #			Home Phone #				

**GROUP DISABILITY INSURANCE**

**Monthly Benefit Being Applied For:**  \$100  \$500  \$750  \$1,000  \$1,250  \$1,500  \$2,000  \$2,500  \$3,000  \$3,500  \$4,000  \$4,500  \$5,000  
The sum of all Group Disability Benefits cannot exceed 60% of an applicant's insured earnings as defined by Guardian.

**Elimination Period:**  90 days  180 days  360 days      **Maximum Payment Period:**  To Age 65 ADEA  2 years  5 years

**Have you:** For each "yes" answer, complete the Medical History Detail on the reverse side.

1. Ever applied to Guardian for Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No , If Yes, list plan/policy number:		
2. Ever been rated, declined, for life, accident or health insurance or ever had such insurance postponed, modified or renewal declined, or received disability for more than 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	
3. Ever been treated by a medical professional for or diagnosed as having the HIV infection?	<input type="checkbox"/> Y <input type="checkbox"/> N	
4. In the past 10 years treated for or diagnosed as having:		
a. High blood pressure, chest pain or disorder of the heart or circulatory system?	<input type="checkbox"/> Y <input type="checkbox"/> N	
b. Diabetes, cancer, tumor, or disorder of the glands, bone or skin?	<input type="checkbox"/> Y <input type="checkbox"/> N	
c. Complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary system?	<input type="checkbox"/> Y <input type="checkbox"/> N	
d. Hernia, hepatitis, or disorder of the liver, gall bladder, stomach, intestines or rectum?	<input type="checkbox"/> Y <input type="checkbox"/> N	
e. Arthritis, rheumatism, or disorder of the joints, limbs or muscles?	<input type="checkbox"/> Y <input type="checkbox"/> N	
f. Disorder or condition of the back, neck or spine?	<input type="checkbox"/> Y <input type="checkbox"/> N	
g. Allergy, asthma, sinusitis, emphysema, or disorder of the lungs or respiratory system?	<input type="checkbox"/> Y <input type="checkbox"/> N	
h. Epilepsy, stroke, dizziness, headache, or disorder of the brain or spinal cord?	<input type="checkbox"/> Y <input type="checkbox"/> N	
i. Disorder of the eyes, ears, nose, or throat?	<input type="checkbox"/> Y <input type="checkbox"/> N	
j. Anxiety, depression, nervousness, stress, mental or nervous disorders, or other emotional disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	
k. Chronic Fatigue Syndrome, Epstein Barr virus or Lyme disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	
l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or any other disorder of the immune system?	<input type="checkbox"/> Y <input type="checkbox"/> N	
5. Within 10 years ever used drugs other than as prescribed by a physician; been advised to have treatment or been treated for drug abuse or alcoholism?	<input type="checkbox"/> Y <input type="checkbox"/> N	
6. In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	<input type="checkbox"/> Y <input type="checkbox"/> N	
7. In the past 5 years:		
a. consulted or been examined by or treated by a physician, practitioner, or specialist? Do not include routine annual physicals unless: (1) they were in connection with an existing or prior medical condition; (2) existing symptoms were being checked; or (3) a specific medical condition was found.	<input type="checkbox"/> Y <input type="checkbox"/> N	
b. been in a hospital, sanitarium, or other institution for observation, diagnosis, treatment, or an operation, or	<input type="checkbox"/> Y <input type="checkbox"/> N	
c. been prescribed medication(s)?	<input type="checkbox"/> Y <input type="checkbox"/> N	
8. In the last 12 months used tobacco in any form? if yes, form used _____	<input type="checkbox"/> Y <input type="checkbox"/> N	
9. Any loss of hearing or sight, an amputation of any kind, any physical deformity, impairment or handicap?	<input type="checkbox"/> Y <input type="checkbox"/> N	
10. Are you pregnant? If Yes, List due date: mo. _____ day _____ yr _____ Any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Have you:</b>		
11. In the last 2 years, participated in any of the following avocations:		
(a) piloting any type of aircraft? <input type="checkbox"/> Y <input type="checkbox"/> N	(b) mountain climbing? <input type="checkbox"/> Y <input type="checkbox"/> N	(c) scuba diving below 100 feet ? <input type="checkbox"/> Y <input type="checkbox"/> N
(d) skydiving ? <input type="checkbox"/> Y <input type="checkbox"/> N	(e) motor vehicle racing? <input type="checkbox"/> Y <input type="checkbox"/> N	(f) martial arts? <input type="checkbox"/> Y <input type="checkbox"/> N
12. In the past two years, had a driver's license suspended or revoked, or had 3 or more moving violations, or been charged with driving under the influence of alcohol or drugs? If yes, Explain: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	

Medical History Detail For each "yes" answer to questions 1 through 9 give details below. (*Continue on a separate sheet if additional space is needed.)					
Ques No.	Dates Mo/Year	Condition/Disorder	Duration of symptoms, treatment & degree of recovery	Practitioner's Name and Address	Hospital Name & Address

I hereby represent that the statements and answers to the questions on this application are to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy these requirements ; (3) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (4) the administrator is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

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.

#### Investigative Consumer Report

I authorize The Guardian Life Insurance Company of America or its legal representative to obtain or have prepared an investigative report as described in the Insurance Information Practices Notice.

#### Medical Records and Other Information

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me.

I understand The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization will be as valid as the original.

I acknowledge receipt of and have read Guardian's Insurance Information Practices Notice regarding its Insurance Information Practices, the Fair Credit Reporting act, the Medical Information Bureau and Medical Records.

I agree that this authorization will be valid for two and one half years from the date shown below.

Signature of Member X		Date			
Planholder Name: Association Insurance Trust		Group Plan No. G-00458022		Class N/A	
<b>ENDORSEMENT (GUARDIAN USE ONLY)</b>					
Signature of Licensed Agent:			Date:		
Planholder Administrator: BPC Financial Address: 7645 Gate Parkway, Suite 101		City Jacksonville	State FL	Zip 32256	Phone Number (904) 396-3696
Disability <input type="checkbox"/> Approved <input type="checkbox"/> Declined		Monthly Benefit \$ _____			
Effective Date:	By:	Date		Secretary	



PLEASE SELECT PAYMENT METHOD:

I wish to use Monthly Auto-Pay. I have included a VOID check and completed the Authorization below.

I hereby authorize BPC Financial to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. BPC Financial will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law and that BPC Financial and the Financial Institution may discontinue this service.

This authority is to remain in full force and effective until BPC Financial and the Financial Institution have received written notice from me of its termination in such time and manner as to afford BPC Financial and the Financial Institution a reasonable opportunity to act on it. Note: If the ACH debit is returned for non-sufficient funds, a \$25 nonrefundable service fee will be applied when allowed by law.

Payor Name (as it appears on Account)	Name of Financial Institution

ATTACH VOID CHECK HERE

Please bill me Annually. By selecting this method, if you are approved for coverage, you will receive your certificate of insurance and an initial invoice for the required premium to pay your coverage and AOP membership dues up through the end of the plan year (Dec. 31st). Thereafter, you will be billed on a calendar annual basis.

AOP MEMBERSHIP AGREEMENT:

I hereby enroll for membership in the ASSOCIATION OF PROFESSIONALS (AOP). Upon completion of this enrollment form and payment of initial dues (\$2.00 monthly), I understand that: (a) I will be entitled to AOP's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Guardian Life Insurance Company Application for Insurance to AOP.

PLEASE SIGN AND DATE:

Signature of Member	Date
X	

## INSURANCE INFORMATION PRACTICES NOTICE

Read and Detach for your records

Thank you for choosing Guardian insurance. This Insurance Information Practices Notice is given to you at the time you apply for disability insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information.

**Fair Credit Reporting Act Pre-Notice:** When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living except as may be related directly or indirectly to your sexual orientation. It will be obtained through personal interviews with people who know you. You may request to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied.

At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. You may inspect and receive a copy of such report by contacting the consumer reporting agency directly. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

**Medical Information Bureau Pre-notice:** The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files. Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the 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 to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

**Medical Records:** We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

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.

**I authorize** any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me.

**I understand** The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

**I know** that I may request and receive a copy of this authorization.

**I agree** that a photocopy of this authorization shall be as valid as the original.

**I acknowledge** receipt of and have read Guardian's notice regarding its Insurance Information Practices Notice.

**I agree** that this authorization shall be valid for two and one half years from the date signed.