

APPLICATION FOR BUSINESS OVERHEAD EXPENSE INSURANCE

For members of the Arkansas State Dental Association

PERSONAL INFORMATION

Name of Organization: Arkansas State Dental Association
 Name: _____
 Social Security Number: _____
 Company Name: _____
 Home Telephone No.: _____
 Billing Address: _____

 Business Telephone No.: _____
 Fax Number: _____
 E-mail: _____
 Please fill in your Daytime Phone Number to assist us in contacting you should the need arise in processing your application: (_____) _____
 Occupation: _____
 Are you now working at least 30 hours per week with your present employer? Yes No
 Beneficiary Name: _____
 Relationship To You: _____
 I wish to pay premiums: Annually Semi-Annually

I WOULD LIKE TO APPLY FOR BUSINESS OVERHEAD EXPENSE INSURANCE

Average monthly amount of eligible overhead expenses in the preceding six months? \$ _____ per month
 Type of Organization:
 Proprietorship
 Corporation
 Partnership
 If Corporation or Partnership, my share of eligible expenses are: _____ %
 Indicate the monthly benefit desired: \$ _____ (up to \$15,000, in \$100 increments)
 Indicate Waiting Period:
 15-day
 30-day
 Benefit Period: **24 months**
 Optional Riders (Check if desired):
 Guaranteed Purchase Option
 Recovery Benefit Option

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Height _____ ft. _____ in. Weight _____ lbs. Sex M F Date of Birth ____/____/____ Place of Birth _____

1. Have you ever had or been treated for: (Circle specific disorders experienced)
 - a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? Yes No
 - b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes No
 - c. Arthritis, gout, bursitis or rheumatism? Yes No
 - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? Yes No
 - e. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder? Yes No
 - f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? Yes No
 - g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? Yes No
 - h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? Yes No
 - i. Menstrual, uterine, or ovarian disorder, disorder of the breast? Yes No
 - j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? Yes No
 - k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes No
 - l. Mental or emotional problem requiring help of a physician or psychologist? Yes No
 - m. A surgical operation? A surgical operation advised but not performed? Yes No
2. Have you ever had treatment by, or consultation with, any hospital, institution, physician, or practitioner within the past five years? Yes No

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION →

DISCLOSURE NOTICE – Medical Information Bureau (MIB)

(This Notice must be detached and retained by the applicant.)

Information regarding your insurability will be treated as confidential. United States Life Insurance Company, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or submit a claim for benefits to such company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your files. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with 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 number is (617) 426-2660.

United States Life, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

APPLICATION FOR BUSINESS OVERHEAD EXPENSE INSURANCE
 CONTINUED FROM FRONT SIDE OF APPLICATION
For members of the Arkansas State Dental Association

Please print or type all information

If you answered "Yes" to questions 1 a-m or 2, please explain fully in the chart below.
 Should you require additional space, please use a separate sheet of paper, signed and dated, and attach it to this form.

Question	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted

What other Business Overhead Expense insurance do you now carry or have an application pending for?
 Give Full Details:

Type of Coverage	Insurance Company	Amount of Monthly Benefit	How long are benefits payable?	
			Accident	Sickness

Are you replacing any current business overhead expense coverage you have? Yes No
 If "Yes", provide name of Insurance Company and Policy Number: _____

DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

1. To the best of my knowledge and belief, all statements made on this application are true and complete.
2. I understand that my application for insurance will be accepted or declined on the basis of these statements.

AUTHORIZATION

I authorize the sources stated on the MIB Disclosure to give to United States Life Insurance Company, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional, any hospital, clinic or other medical care institution; any insurer, the Medical Information Bureau; any consumer reporting agency; any employer. I understand that this information will be used by United States Life Insurance Company to determine eligibility for insurance.

I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action that United States Life Insurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier. I know that I have the right to receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original.

Fraud Statement — Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

 (Date Signed) (Signature of Proposed Insured)

Just complete this application and return it today!

Mail your application to:
 Regions Insurance, Inc. • 1500 Riverfront Drive • P.O. Box 3398 • Little Rock, AR 72203-3398
Questions? Call 1-888-272-6656

