**PART 1**

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
## 401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880

**Instructions**:
- **Complete only in the presence of the Proposed Insured**
- **Please PRINT in black ink and initial all changes**
- **Answer all questions in their entirety - Unanswered questions will delay the processing**
- **"N/A" is an unsatisfactory answer and will not be accepted**
- **USE OF LIQUID WHITEOUT OR LIQUID PAPER will not be accepted**

1. Proposed Insured (You): ______________________________

   Address: ______________________________
   (Street)

   ______________________________ / ______________ / ______________
   (City) (State) (Zip)

   Soc. Sec. No: _____ / _____ / _____   Sex: M ☐ F ☐   Weight: __________   Height: __________

   Date of Birth: _____ / _____ / _____   Place of Birth: ______________________________
   Month Day Year

2. Assured (Applicant and Owner if other than Proposed Insured): ______________________________

   Address: ______________________________
   (Street)

   ______________________________ / ______________ / ______________
   (City) (State) (Zip)

   Soc. Sec. No: _____ / _____ / _____   Tax I.D. Number: _____ / _____ / _____

3. Employer: ______________________________

   Address: ______________________________
   (Street)

   ______________________________ / ______________ / ______________
   (City) (State) (Zip)

4. Name of Beneficiary (if other than Proposed Insured): ______________________________

   Soc. Sec. No: _____ / _____ / _____   Tax I.D. Number: _____ / _____ / _____

   Beneficiary Address: ______________________________
   (Street) (City) (State) (Zip)

   Relationship to Proposed Insured: ______________________________

5. Occupation of Proposed Insured: ______________________________

   Job Title: ______________________________

6. Nature of Business: ______________________________

   Describe, in order of importance, all major duties of your occupation.

| Description of Duties | % of time devoted to this activity |
|---|---|
| | |
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# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
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7. **PERSONAL FINANCIAL INFORMATION OF THE PROPOSED INSURED**

a) Earned income means the compensation which you receive for work or personal services, after business expenses, but before any other deductions, as reported for federal income tax purposes on IRS Form 1040.

Earned income does not include passive or unearned income from dividends, interest, rentals or royalties. It is not Adjusted Gross Income.

Fill in the amounts that are (or will be) shown on your federal income tax forms and supporting schedules. Do not enter any amounts that are not reported to the IRS.

| b) **EARNED INCOME** | **Current Year** Estimated<br>Jan 1 - Dec 31<br>**20** _______ |
|---|---|
| 1. Salary or Wages from Form W2 | _______________ |
| 2. Sole Proprietor Net Proft from 1040 Schedule C | _______________ |
| 3. Share of Partnership or S Corp Non-Passive Income from 1040 Schedule E | _______________ |
| 4. Pension Plan Contributions or Elective Deferred Compensation which would cease if the Proposed Insured were disabled | _______________ |
| 5. Bonus, Commission or Other Earned Income from this occupation (explain in Remarks below) | _______________ |
| 6. Other Earned Income from any other full or part time work (explain in Remarks below) | _______________ |
| **TOTAL EARNED INCOME** (Add above amounts) | _______________ |
| c) **UNEARNED INCOME** including passive income, if it exceeds $20,000 in either of the last two years. If not applicable, so state. | _______________ |

d) **NET WORTH** Is your net worth greater than $4,000,000? Yes ☐ No ☐

If yes, describe your net worth in detail. Show current value less indebtedness.

| | | | |
|---|---|---|---|
| Cash, savings, stocks and bonds | $__________________________ | Personal property | $________________________ |
| Business | $__________________________ | Personal residence | $________________________ |
| Other real estate | $__________________________ | Other | $________________________ |

e) Explain any fluctuations in income that exceed 20% of the prior year, or any special circumstances that may affect your earned income, in the Remarks section below.

**Remarks**: ____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

**PART 1**

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
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8. Are You now at work at least 30 hours a week in this occupation? Yes ☐ No ☐

9. Number of years in this occupation? ________ with this Employer? ________

10. Former occupation, if changed within two years ________________________________

11. Do You have any other part or full time jobs? Yes ☐ No ☐

    If Yes, describe: ________________________________

    ________________________________

12. If an owner, percentage owned ________% Years owned ________ Number of Employees ________

13. Type of Business Entity: ____ Sole Proprietor _____ Partnership _____ S Corp ______ C Corp

    Other (Describe): ________________________________

14. List all disability insurance You now have in Force or have applied for in all companies:

    If NONE, check here: ________

    Code Type of Insurance: IND = Individual G = Group A = Association I = In Force P = Pending Or Date of Eligibility

| Insurance Company | Type: Personal Disability Income/Key Person/Overhead/ Buy Out | Type: IND, G or A | Amount of Lump Sum OR Monthly Indemnity | Benefit Period Accident/Sickness | I, P or Date of Eligibility |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |

15. Will You become eligible for group disability income insurance in the next six months? Yes ☐ No ☐

16. Do you pay Social Security taxes (FICA or Schedule SE)? Yes ☐ No ☐

17. **REPLACEMENT**

    Will this Houston Casualty Corp. Certificate/Policy replace any other disability insurance? Yes ☐ No ☐

    If yes, provided details below:

    When issuing any insurance as a result of this Personal Accident and Sickness Application, the Company will rely on the fact that the Proposed Insured and/or the Assured and/or the Employer can and will permanently terminate the coverage(s) listed below by the next premium due date following delivery of the Houston Casualty Corp. Certificate/Policy. The Company may contact any listed insurer after the date shown to confirm that the coverage has been permanently terminated.

| Insurance Company | Type: Personal Disability Income/Key Person/Overhead/ Buy Out | Group or Association Name | Policy No. | Amount to be Replaced | Next Premium Due Date & Mode |
|---|---|---|---|---|---|
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# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
## 401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880

**Instructions**: Please **PRINT in black** and **initial all changes** - **Answer all questions in their entirety**

**Unanswered questions will delay the processing - "N/A" is an unsatisfactory answer and will not be accepted**

## HEALTH HISTORY

1. **Proposed** Insured:______________________________

   Date of Birth: ________/________/________ (Month / Day / Year) Sex: M ☐ F ☐ Occupation: ______________________

2. Hospitalizations:

   Have You ever been a patient, either inpatient or outpatient, in a hospital, clinic or other medical facility? Yes ☐ No ☐
   If Yes, please provide full details. Include all years, name of facilities, duration of injury, sickness, surgery and treatment.

   ______________________________ ______________________________
   ______________________________ ______________________________
   ______________________________ ______________________________

3. Medications:

   a. Do You presently take any prescribed medicines? Yes ☐ No ☐
      If Yes, list name(s), dosage, how often You take it and reason(s) for taking each.

      ______________________________ ______________________________
      ______________________________ ______________________________
      ______________________________ ______________________________

   b. During the past five (5) years, have You taken any prescribed medicines (including any cortisone shots or any pain reducing or anti-inflammatory medications or treatments)? Yes ☐ No ☐
      If Yes, list name(s), dosage, how often You took it and reason(s) for taking each.

      ______________________________ ______________________________
      ______________________________ ______________________________
      ______________________________ ______________________________

   c. Do You presently take any non-prescription (over-the-counter) medicine(s) or tonics? Yes ☐ No ☐
      If Yes, list name(s), dosage, how often You take it and reason(s) for taking each.

      ______________________________ ______________________________
      ______________________________ ______________________________
      ______________________________ ______________________________

4. Have You ever suffered from or ever been medically treated by a physician, chiropractor, psychiatrist, psychologist or drug & alcohol or mental counselor for:

   a. glaucoma, cataracts, failing vision not corrected with glasses or contact lenses, persistent hoarseness, loss of hearing or any other disease, injury, syndrome or disorder of the eyes, ears, nose, mouth or throat? Yes ☐ No ☐

   b. neuritis, sciatica, arthritis, gout, or any other disease, syndrome or disorder of the muscles, nerves, cartilage or bones; including but not limited to the spine, back, knees, shoulders, or elbows or any other joints? Yes ☐ No ☐

   c. chest pain, palpitation, arrhythmia, heart attack, angina, high blood pressure, heart murmur or any other cardiovascular disease, syndrome or disorder of the heart? Yes ☐ No ☐

**PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED “YES”**

PERSONAL ACCIDENT AND SICKNESS APPLICATION

**HCC SPECIALTY UNDERWRITERS, INC.**
**401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880**

## HEALTH HISTORY

d. colitis, ulcer, hernia, diverticulitis, hepatitis, or any other disease, syndrome of the stomach, intestines, liver, gall bladder, rectum or pancreas? Yes ☐ No ☐

e. shortness of breath, persistent cough, asthma, tuberculosis or any other respiratory disease, syndrome or disorder? Yes ☐ No ☐

f. any sexually transmitted disease, sugar, albumin protein, blood or pus in the urine or an infection or disorder of the kidneys, bladder, urinary tract, prostate or reproductive organs? Yes ☐ No ☐

g. dizziness, fainting, convulsions, seizures, severe or persistent headaches, depression, stress, chronic fatigue, mononucleosis, paralysis, stroke or any emotional, nervous, behavioral or mental problem, disease, syndrome, disorder or illness? Yes ☐ No ☐

h. unexplained weight gain or loss of more than 20 pounds, diabetes or any other disease, syndrome, or disorder of the thyroid, pituitary, adrenal or parathyroid gland? Yes ☐ No ☐

i. allergies or any other disease, syndrome or disorder of the skin or lymph glands? Yes ☐ No ☐

j. hysterectomy or prostatectomy or any other disease, syndrome or disorder of the breasts, uterus, tubes, ovaries, vagina, penis, prostate or testicles? Yes ☐ No ☐

k. anemia, hemophilia, clotting disorder, leukemia, or any other disease, syndrome or disorder of the blood or blood vessels? Yes ☐ No ☐

l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? Yes ☐ No ☐

m. cysts, tumor or cancer, either benign or malignant? Yes ☐ No ☐

n. **ANY OTHER INJURY, ILLNESS, SICKNESS, DISEASE OR SYNDROME, CONGENITAL DEFORMITY, ABNORMALITY OR DISORDER NOT LISTED OR MENTIONED ABOVE?** Yes ☐ No ☐

5. Have you:

   a. used or abused marijuana, cocaine, heroin, morphine, barbiturates, amphetamines, hallucinogens or any other drug? Yes ☐ No ☐

   b. sought or received or been recommended to receive advice or treatment of, or been arrested for the possession of, use or abuse of alcohol or drugs? Yes ☐ No ☐

6. Has any BLOOD RELATIVE of Yours ever suffered from a stroke or cancer, heart, or kidney, or diabetes, or high blood pressure disease, syndromes or disorders or mental or emotional disease, syndromes or disorders? Yes ☐ No ☐

7. Have you:

   a. within the past five (5) years, obtained license or participated in hunting, piloting, parachuting, sky diving, snow skiing, water skiing, scuba diving, motor racing, or any other similar type sport(s) or activity(ies)? Yes ☐ No ☐

   If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

   ___________________________________________

   ___________________________________________

   ___________________________________________

   b. Are You currently or do You intend to obtain license or participate in any sport(s) or similar type of activity(ies) as shown in 7.a. above? Yes ☐ No ☐

   If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

   ___________________________________________

   ___________________________________________

   ___________________________________________

**PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"**

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

**HCC SPECIALTY UNDERWRITERS, INC.**
**401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880**

## HEALTH HISTORY

8. Have you ever been convicted of a felony (including a plea of guilty)? Yes ☐ No ☐
   If Yes, provide reason(s) and date(s) of each such occurrence.
   ______________________________________________
   ______________________________________________
   ______________________________________________

9. Have you ever been convicted of a misdemeanor (including a plea of guilty)? Yes ☐ No ☐
   If Yes, provide reason(s) and date(s) of each such occurrence.
   ______________________________________________
   ______________________________________________
   ______________________________________________

**PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"**

**PART 2**

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
## 401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880

**Provide full, specific details in the space below for any questions answered "Yes"**

Including “Yes” or “No” as to whether or not FULL RECOVERY

| Question No. and Item No. | Symptoms and/or Diagnosis, recommended Treatment(s), and Current Treatment(s) | Date(s) of Symptoms, Treatment(s) and/or Surgery(ies) | Date(s) of Each Occurrence | Time Lost from Occupation | Name, Address, Phone & Fax #'s for all Physician(s) and Hospitals, Clinics & Health Care Facilities | Full Recovery |
|---|---|---|---|---|---|---|
| | | | | | | ☐Yes ☐No |
| | | | | | | ☐Yes ☐No |
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| | | | | | | ☐Yes ☐No |
| | | | | | | ☐Yes ☐ No |

**CONTINUE ON PAGE 8, IF NEEDED**

**PART 2**

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

**HCC SPECIALTY UNDERWRITERS, INC.**
**401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880**

**Continue Full, Written Details of All Questions Answered "Yes"**

*A signed Notice and Authorization to obtain Information must be attached for this to be a complete part of this Application*

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

**HCC SPECIALTY UNDERWRITERS, INC.**
**401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880**

## FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURER, THE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I, the Proposed Insured, declare that all responses made to each and every question in this Application, are true and complete.

I, the Proposed Insured, understand that:

(a) any false statements or material misrepresentations shall result in the loss of coverage(s) under any policy and/or certificate which may be in force **and/or** any coverage(s) which are being offered; and

(b) no representation made to or information possessed by any agent shall be binding on the Company and/or the Insurer, unless disclosed in this Application.
.

________________________________ (Signature of Proposed Insured)    ________________________ (Print Name)

Date:_____/_____/_____ (Month Day Year)    Signed at:________________________ City and State

________________________________ (Signature of Assured)    ________________________ (Print Name)

Date:_____/_____/_____ (Month Day Year)    Signed at:________________________ City and State

Agent/ Broker Signature: ________________________    ________________________ (Print Name)

**ALL FORMS SHOULD BE RETURNED DIRECTLY TO:**

**HCC SPECIALTY UNDERWRITERS, INC.**
401 Edgewater Place, Suite 400
Wakefield, MA 01880
TEL: 781-994-6000 FAX: 781-994-6001

# PERSONAL ACCIDENT AND SICKNESS APPLICATION

## HCC SPECIALTY UNDERWRITERS, INC.
## 401 EDGEWATER PLACE, SUITE 400, WAKEFIELD, MA 01880

### NOTICE TO PROPOSED INSURED

As a part of Our normal procedure for processing Your application We may get an investigative consumer report. Information may be secured through personal interviews with your friends, neighbors and others with whom You are acquainted. This report typically contains information as to Your character, general reputation, personal characteristics, and mode of living. Within a reasonable period thereafter, You have the right to request in writing a complete and accurate disclosure of additional information concerning the nature and scope of this report, including the name and address of the consumer reporting agency to whom the request was made. Upon the furnishing to You of the name and address of the consumer reporting agency to whom the request was made, We will also inform You that You may inspect and receive a copy of such report by contacting such agency. Please address Your request to "Underwriting Department," HCC SPECIALTY UNDERWRITERS, INC., 401 Edgewater Place, Suite 400, Wakefield, MA 01880.

These reports are made in Your best interests, in that We try to be sure that Insureds meet certain standards so that We can continue to offer coverage at the lowest possible cost to all who qualify.

### NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU
**Please Read Carefully**

Information regarding Your insurability will be treated as confidential. We 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.

We may also make information in Our file available to reinsurance companies and to other life insurance companies to whom You may apply for life or health insurance, or to whom You submit a claim for benefits.

Upon receipt of a request from You, the Bureau will arrange disclosure of any information it may have in Your file. (Medical information will be disclosed only to Your attending physician.) If You question the accuracy of information in the Bureau's file, You may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. For U.S residents, the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

### AUTHORIZATION

You hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of You or Your health, to give to the Company and/or the Insurer any such information, to the extent permitted by law. You also hereby authorize the Company and/or the Insurer to procure or cause to be prepared an investigative consumer report. You expressly waive under this application, all provisions of the law prohibiting disclosure of information obtained as a result of Your authorization, and You expressly authorize such disclosures and authorize testimony as to such information. You acknowledge receipt of the "**NOTICE TO PROPOSED INSURED**". A photographic copy of this acknowledgment shall be as valid as the original.

Date: ______________________ ______________________________________
Month / Day / Year — Signature of Proposed Insured (Referred to as "You", "Your")

Date: ______________________ ______________________________________
Month / Day / Year — Signature of Witness