

ACCIDENTAL DEATH ONLY or ACCIDENTAL DEATH & DISMEMBERMENT APPLICATION

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

Instructions: Please PRINT in black ink and Initial ALL changes • Answer all questions in their entirety • Any unanswered questions will delay the processing • "N/A" or "None" are unsatisfactory answers and will not be accepted • USE OF LIQUID WHITEOUT OR LIQUID PAPER will not be accepted

1. Assured / Policyholder: (If other than Proposed Insured)

Address: (Street), (City), (State / Territory / Province), (Zip)

2. Proposed Insured: (Last), (First), (Middle)

Soc. Sec. No: Sex: M F Weight: Height:

3. Date of Birth: (Month / Day / Year) Place of Birth:

4. Residence of Proposed Insured: (Street), (City), (State / Territory / Province), (Zip)

5. Occupation: Annual Earnings:

6. Beneficiary Designation for Accidental Death:

(a) First Beneficiary: (Name), (Relationship)

(b) Contingent Beneficiary: (Name), (Relationship)

7. Does the Proposed Insured and/or Assured/Policyholder currently have or plan to purchase any other death and/or disability insurance on the Proposed Insured? Yes No If yes, provide the name(s) of insurer(s), details & type(s) of coverage(s) and benefit amount(s) and policy term(s):

8. Has the Proposed Insured been hospitalized within the past five (5) years? Yes No If yes, provide approximate date and reason for each hospitalization:

9. Does the Proposed Insured have any physical defect or infirmity? Yes No If yes, provide full details of defect and/or infirmity including treatment(s) and medication(s):

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10. Has any Life, Health or Accident insurer ever canceled or declined to accept any application or renewal, or only accepted or renewed or quoted on special rates, terms or conditions, any insurance on the Proposed Insured?

Yes No If yes, provide reason(s) for declination, special terms and/or conditions:

11. Has the Proposed Insured had any Driver's License revoked, suspended or restricted?

Yes No If yes, provide reason(s) and dates(s) for each occurrence:

12. Has the Proposed Insured and/or Assured/Policyholder ever made any claim(s) against any insurer for death and/or disability resulting from injury or sickness?

Yes No If yes, provide the name(s) and date(s) of all claims and the amount(s) of benefit(s) received from any insurer or self-insured plan:

13. Has the Proposed Insured within five (5) years, obtained license, participated in or intend to participate in, and/or is currently participating 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:

14. Has the Proposed Insured ever been convicted of a felony (including a plea of guilty)?

Yes No If yes, provide reason(s) and dates(s) of each such occurrence:

15. Has the Proposed Insured ever been convicted of a misdemeanor (including a plea of guilty)?

Yes No If yes, provide reason(s) and dates(s) of each such occurrence:

16. Does the Proposed Insured intend to travel during the term of this proposed insurance?

Yes No If yes, provide estimated number of:

- (a) flights by scheduled air: _____
- (b) flights by non-scheduled air or charter lines: _____
- (c) flights by company-owned planes: _____
- (d) flights by private planes: _____

17. Does the Proposed Insured intend to undertake any foreign travel during the term of this proposed insurance?

Yes No If yes, provide details of country(ies) you will visit, length of each stay and purpose of each visit:

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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, Part 1, 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, Part 1.

 Signature of Proposed Insured

 Print Name

Date: _____
 Month / Day / Year

Signed at: _____
 City, State / Territory / Province, Country

 Signature of Assured/Policyholder
 (if other than Proposed Insured)

 Print Name and Title

Date: _____
 Month / Day / Year

Signed at: _____
 City, State / Territory / Province, Country

 Signature of Agent / Broker

 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

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(referred to as "We", "Our")

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