

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 • Any unanswered questions will delay the processing • "N/A" or "None" are unsatisfactory answers and 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: _____ Place of Birth: _____
(Month / Day / Year)

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

5. Occupation: _____

6. Does the Proposed Insured engage in any other full or part-time occupation and/or employment, including Endorsement Contracts or any other similar financial agreement?
 Yes No If yes, provide full details of occupation/employment, agreement, compensation and duties:

7. Has the Proposed Insured had any Driver's License revoked, suspended or restricted?
 Yes No If yes, provide reason(s) and date(s) for each occurrence:

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

9. Has any Life, Health or Accident insurer or self-insured plan ever canceled, declined to accept any application or renewal, or only accepted, 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:

10. Has the Proposed Insured and/or Assured/Policyholder ever made any claim(s) against any insurer or self-insured plan for disability resulting from injury or sickness?
 Yes No If yes, provide the name(s), date(s) of all claim(s) and the amount(s) of all benefit(s) received from any insurer or self-insured plan:

11. Has the Proposed Insured, within the past three (3) years, failed to participate in five (5) or more games, (including any pre-season or post season games), for any reason including injury(ies) and/or sickness?
 Yes No If yes, provide details of injury(ies) and/or sickness including dates and duration for each:

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12. Has the Proposed Insured, within the past 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:

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

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

14. Within the past five (5) years, has the Proposed Insured been convicted of a misdemeanor (including a plea of guilty)?

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

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Health History

1. Assured/Policyholder: (if other than Proposed Insured)
2. Proposed Insured ("You"): (Last) (First) (Middle)
Date of Birth: (Month / Day / Year) Sex: M F Occupation:

3. 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, specific details. Include the year(s), names of facilities, duration, injury, sickness, surgery and treatment. Year(s)

4. Medications:

a) Do You presently take any prescribed medicines? Yes No
If "Yes", provide prescribing physician's name(s) and list name(s) & dosage of each medicine, 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 shot(s), or any pain reducing or anti-inflammatory medication(s) and/or treatment(s)? Yes No
If "Yes", provide prescribing physician's name(s) and list name(s) & dosage of each medicine, 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
(For example, laxatives, diet pills, dietary supplements, vitamins, antacids, cold medicines, etc.)
If "Yes", list name(s), dosage of each medicine, how often You take it and the reason(s) for taking each.

d) Within the past five (5) years have You had any injury(ies) or sickness(es) which has caused discomfort or pain for which medical advice(s) and/or treatment(s) have not yet been sought? Yes No

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

5. Allergies:

Are You allergic to or have You ever had an adverse reaction to any prescription or non-prescription medicine(s), or other substance(s)? Yes No

If "Yes", list name of medicine(s) & Your allergic reaction to each:

6. Health Habits:

a. Do You currently smoke cigarettes? Yes No

b. If You do not currently smoke cigarettes, have You ever smoked cigarettes? Yes No
If you answered "No", go on to #6.e.

c. If You currently smoke or You have ever smoked cigarettes:

- How many packs per day; and For how many years?
1/2 pack or less 5 years or less
1/2 to 1 pack 5 to 10 years
1 to 1 1/2 packs 10 to 15 years
1 1/2 to 2 packs 15 to 20 years
More than 2 packs More than 20 years

d. If You are an ex-smoker, how long ago did You stop smoking?
6 months or less 2 to 10 years ago
6 to 12 months ago More than 10 years ago
1 to 2 years ago

e. Do You currently chew / dip smokeless tobacco? Yes No
If "Yes", for how many years have you done so? _____

f. If You do not currently chew / dip, did You ever? Yes No
If "Yes", for how long? _____ When did you stop? _____

g. How many pouches of chew tobacco / cans of snuff did/do You use per week?
_____ pouches of chewing tobacco per week _____ cans of snuff per week

h. Have You ever noticed sores, white patches or gum problems where the tobacco is held? Yes No

i. On the average, how many drinks do You have per day?
One drink = One 12 oz. beer
= One 4 oz. glass of wine
= One 1 oz. shot of whiskey
Weekdays and Weekends
None None
0 - 2 0 - 2
3 - 5 3 - 5
6 - 10 6 - 10
More than 10 More than 10

j. Have You ever tried to cut down on drinking? Yes No

k. Have You ever been annoyed by criticism of Your drinking? Yes No

l. Have You ever been recommended to or sought or received counseling or advice for, treatment of, or been arrested for possession or use of alcohol, marijuana or other drug(s)? Yes No

m. Except as legally used as prescribed by a physician, have You ever used cocaine, barbiturates or any narcotic drug(s) or any other substance not lawfully available without a prescription? Yes No

n. Have You ever been advised by a physician or dietitian to modify Your diet? Yes No

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

7. Family History:

Have You or any blood relative(s) had health problems with any of the following? If yes, indicate by X's which of the following health problems You, or any blood relative(s) have had:

	<u>NO</u>	<u>Self</u>	<u>YES</u> <u>Relative</u>	Indicate Relationship (mother, father, sister, etc.)
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer(s) (any type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon / polyp(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon/rectal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other cancer(s) - Specify type(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYMPTOMS, CONDITIONS AND PROBLEMS BY SYSTEMS

1. Endocrine:

Within the past 12 months, have You had:

1. an unexplained weight gain of 20 lbs. or more? Yes No
2. an unexplained weight loss of 20 lbs. or more? Yes No
3. heat intolerance? Yes No
4. cold intolerance? Yes No
5. excessive appetite? Yes No
6. unusual thirst? Yes No
7. abnormal hair growth? Yes No
8. a change in Your sexual drive? Yes No

Have You ever had:

9. sugar diabetes? Yes No
10. x-ray treatment(s) of Your face, tonsils or neck? Yes No
11. treatment for thyroid problem(s)? Yes No
12. Surgery:
 - a. thyroid gland operation? Yes No
 - b. parathyroid gland operation? Yes No

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

2. Eyes, Ears, Nose, Throat:

Within the past 12 months, have You had:

- 1. recurrent or frequent eye pain?
2. failing vision not corrected with glasses or contact lens(es)?
3. trouble with Your hearing?
4. frequent or recurrent ear pain or discharge?
5. severe nosebleeds?
6. troublesome nasal discharge or stuffy nose?
7. painful teeth?
8. persistent or troublesome sores on the lips or tongue?
9. persistent hoarseness?

Have You ever had:

- 10. temporary loss of vision in one or both eyes?
11. glaucoma?
12. retinal detachment?
13. cataract?
14. allergy testing?
15. Surgery:
a. eye operation?
b. ear operation?
c. nose / sinus operation?
d. mouth or throat operation?

3. Respiratory:

Within the past 12 months, have You:

- 1. had a chronic (daily) cough?
2. coughed up blood?
3. had shortness of breath which interfered with Your normal or daily functions?

Have You ever had:

- 4. tuberculosis?
5. a positive (abnormal) skin test for TB?
6. asthma?
7. any other respiratory disease or disorder?

4. Cardiovascular:

Within the past 12 months, have You had:

- 1. frequent skipped or irregular heartbeats?
2. repeated bothersome chest discomfort or pain?
3. shortness of breath if You lie flat?
4. swollen ankles or feet?
5. painful leg cramps brought on by walking?

Have You ever experienced:

- 6. high blood pressure?
7. angina?
8. a heart murmur?
9. fainting episodes?
10. any other cardiovascular disease or disorder?

5. Gastrointestinal:

Within the past 12 months, have You had:

- 1. persistent difficulty or pain in swallowing?
2. frequent episodes of vomiting?
3. persistent troubles with gas, heartburn, or indigestion?
4. frequent abdominal pains?
5. persistent constipation requiring laxatives?
6. a recent change in bowel habits?
7. blood in or around the stool?
8. blood in the toilet bowl?
9. blood on the toilet paper?
10. black or tarry stools?
11. a recent loss of appetite?

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

5. **Gastrointestinal: (continued)**

Have You ever had:

- 12. ulcer problems? Yes No
- 13. jaundice, hepatitis or other liver disease? Yes No
- 14. ulcerative colitis or regional enteritis? Yes No
- 15. diverticulitis? Yes No
- 16. gall stones? Yes No
- 17. polyp or tumor of the bowel or rectum? Yes No
- 18. Surgery:
 - a. hernia repaired? Yes No
 - b. appendix removed? Yes No
 - c. stomach operation? Yes No
 - d. gall bladder removed? Yes No
 - e. intestinal or rectal operation? Yes No
 - f. any other type of abdominal surgery? Yes No

6. **Genitourinary:**

Within the past 12 months, have You had:

- 1. persistent trouble in passing urine? Yes No
- 2. bloody urine? Yes No
- 3. to get up more often than once at night to urinate? Yes No

Have You ever had:

- 4. an infection of the kidney or bladder? Yes No
- 5. kidney or bladder stones? Yes No
- 6. treatment(s) for venereal disease or other similar disease? Yes No
- 7. Surgery:
 - a. kidney operation? Yes No
 - b. bladder operation? Yes No

7. **Genitourinary - MEN ONLY:**

Within the past 12 months, have You had:

- 1. a discharge from Your penis? Yes No
- 2. a lump or swelling of Your testicle? Yes No
- 3. a decrease of Your sex drive potency more than You think is normal? Yes No

Have You ever had:

- 4. Surgery:
 - a. prostate operation? Yes No
 - b. penis operation? Yes No
 - c. testicle operation? Yes No
 - d. sterilizing operation? Yes No

8. **Hematology:**

Within the past three (3) years, have You had:

- 1. prolonged bleeding (more than is normal for You) from a cut, injury, surgery, or tooth removal? Yes No
- 2. swollen lymph nodes or glands? Yes No

Have You ever had:

- 3. anemia? Yes No
- 4. hemophilia or other bleeding disease? Yes No
- 5. leukemia or other cancer of the blood? Yes No
- 6. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other disease or disorder of the immune system (i. e. chronic fatigue, HIV Positive, mononucleosis)? Yes No
- 7. Surgery:
 - a. spleen removed? Yes No
 - b. biopsy or removal of lymph gland? Yes No

9. **Skin/Breast:**

Within the past three (3) years, have You had:

- 1. a persistent skin rash or problem? Yes No
- 2. moles or skin lumps that have changed either in size or color? Yes No
- 3. lumps or soreness in the breast or nipple(s)? Yes No
- 4. a bloody discharge from the nipple(s)? Yes No
- 5. psoriasis? Yes No

Have You ever had:

- 6. Surgery:
 - a. skin cancer removed? Yes No
 - b. breast operation or biopsy? Yes No

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

10. Musculoskeletal:

Have You ever:

- 1. had any surgery (including arthroscopic procedures)?
2. been an in-patient in a hospital, clinic or other medical facility?
3. had neuritis, sciatica or arthritis?
4. had disease or disorder of any muscles, tendons, ligaments, bones and/or joints?
5. had fracture(s) or dislocation(s) of any bones or joints?
6. had x-ray(s), CT scan(s), MRI(s), arthrogram(s) or bone scan(s)?

Within the past five (5) years, have You had:

- 7. any back pain which interfered with Your daily activity?
8. any ache(s), pain(s) or cramps in any of the muscles and/or joints?
9. to use a cane or crutch for any reason?
10. any injury to any muscles, tendons, ligaments, bones and/or joints not indicated in 1.-9. above?

11. Neurology:

Within the past five (5) years, have You:

- 1. had any injury to the head?
2. had severe headaches?
3. had double vision?
4. had dizzy spells?
5. had loss of consciousness?
6. had blackout spells?
7. lost Your ability to speak for a few minutes?
8. had trouble with memory or coordination?

Have You ever had:

- 9. a stroke?
10. paralysis?
11. multiple sclerosis?
12. seizures?

12. Have You ever felt You suffered from or been told You have, or been treated for, or received counseling, or have been under observation or taken any medication(s) for:

- 1. anxiety?
2. depression?
3. nervous breakdown?
4. nervous debility (fatigue)?
5. suicide attempt?
6. any other emotional disorder or illness?
7. any other nervous disorder or illness?
8. any behavioral problem or disorder?
9. any other mental disease, disorder or illness?
10. any other emotional, nervous or mental illness, disease or disorder or situation or condition, not specifically named above?

13. In the past five (5) years, have You:

- 1. had any x-ray(s), CT scan(s), MRI(s), EMG (electromyogram) or lumbar puncture for any problem other than Musculoskeletal?
2. had an ECG (electrocardiogram), EEG (electroencephalogram), blood and/ or urine serological study or other laboratory test(s)?

Have You ever had:

- 3. an ECG and/or EEG and/or EMG or other laboratory test(s) and were advised or are aware that the results were abnormal?

14. Have You, in the last 12 months, seen any physicians and/or received any treatment not indicated in response to any of the prior questions?

Yes No

If yes, please list the name(s) and address(es) of all physicians with dates you were seen and reason(s) for each visit:

Blank lines for listing physician names and addresses.

15. IN THE PAST 3 YEARS, HAVE YOU HAD ANY OTHER INJURY, ILLNESS, SICKNESS, DISEASE OR SYNDROME CONGENITAL DEFORMITY, ABNORMALITY OR DISORDER OR TREATMENT NOT LISTED OR MENTIONED ABOVE?

Yes No

PROVIDE ON PAGE 9, FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

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 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 INSURANCE 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 and Part 2, 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 Underwriters and/or the Insurer, unless disclosed in this Application, Part 1 and Part 2.

Signature of Proposed Insured	Print Name
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Date: _____
Month / Day / Year

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

Signature of Assured/Policyholder (if other than Proposed Insured)	Print Name and Title
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Date: _____
Month / Day / Year

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

Signature of Agent / Broker	Print Name
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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

HCC SPECIALTY UNDERWRITERS, INC.
401 Edgewater Place, Suite 400, Wakefield, MA 01880
(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.

For Canadian residents, the Canadian Bureau's information office is 330 University Avenue, Toronto, Ontario M5G 1R7, telephone number (416) 597-0590.

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 Underwriters and/or the Insurer any such information, to the extent permitted by law. You also hereby authorize the Underwriters 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