

**CATASTROPHIC DISABILITY  
INCOME INSURANCE APPLICATION**

**Underwritten by:**  
**Unimerica Insurance Company**  
 Association Administrative Address:  
 P.O. Box 17828  
 Portland, Maine 04112-8828  
 Group Policy Number: 1158

**To Apply:** Please complete this form and return to:  
 ASCE Member Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348  
**Questions:** Please call 1.800.650.2723

Trustees of the American Society of Civil Engineers Group Insurance Trust  
**CATASTROPHIC DISABILITY INCOME INSURANCE APPLICATION**

PLEASE PRINT IN INK. DO NOT ERASE OR USE CORRECTION FLUID. TO CORRECT, CROSS OUT AND INITIAL/DATE CHANGES.  
 ANSWER ALL QUESTIONS, THEN SIGN THE AGREEMENT AND AUTHORIZATION.

**1A. Member Information:**

Full Name \_\_\_\_\_  
Last First Middle Initial

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State (or Province) \_\_\_\_\_ Zip Code

Billing Address \_\_\_\_\_

Daytime Phone (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_  
For internal use only. E-mail address will never be sold or shared.

Social Security #:    -   -     Sex:  Male  Female

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Place of Birth: \_\_\_\_\_ Citizenship/Country: \_\_\_\_\_

Beneficiary: \_\_\_\_\_ Relationship of Beneficiary to you: \_\_\_\_\_

Application is made for:  New Coverage  
 Increase / Certificate No.: \_\_\_\_\_ Current Amount of Coverage: \$ \_\_\_\_\_  
 Reinstatement / Certificate No.: \_\_\_\_\_ Amount of Coverage: \$ \_\_\_\_\_

**1B. Membership Affiliation—Occupational Status:**

a. Are you now a member of the ASCE?  Yes  No (Association Membership is required for participation in this plan.)  
 ASCE Membership # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

b. What is your occupation? \_\_\_\_\_ How many hours a week do you work? \_\_\_\_\_

c. Main duties \_\_\_\_\_

**2. Plan Selection: Catastrophic Disability Coverage.**

**A. MAXIMUM MONTHLY BENEFIT (Member coverage only):** \$ \_\_\_\_\_ (\$1,000 to \$10,000 per month, in increments of \$100, not to exceed 100% of your Annualized Monthly Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.)

**B. MAXIMUM BENEFIT PERIOD** (Select one):  60 Months  120 Months  To Age 65

**C. ELIMINATION PERIOD** (Select one):  60 days  90 days  180 days  360 days

**D. OPTIONAL BENEFIT:**  Extended Catastrophic Disability Benefit (Choose an amount between \$10,000 to \$100,000):  
 Member Only: \_\_\_\_\_  Member and Spouse: \_\_\_\_\_ (Complete Spouse Information below.)  
**Spouse Information:** Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
 Place of Birth: \_\_\_\_\_ Citizenship/Country: \_\_\_\_\_

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**5. Member's/Spouse's Statement of Health continued:**

4. During the past 10 years (5 years in IN, KS, and MN), have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details. Except in KS, include conditions for which you have experienced symptoms.
- |  |                          | MEMBER                   | SPOUSE                   |
|--|--------------------------|--------------------------|--------------------------|
|  |                          | YES                      | NO                       |
| a. chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities, or any disease or disorder of the lung? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. diabetes, any glandular, thyroid, or other endocrine disease or disorder? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease, or any chronic pain condition? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia, or immune system? (In ME and WI, excluding HIV) . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. liver, digestive system, either kidney, urinary, or reproductive tract, prostate, or sexually transmitted diseases (Except for HIV)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. loss of hearing or vision, or disease or disorder of the eyes, ears, nose, or throat? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. chronic fatigue, Epstein Barr virus, fibromyalgia? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. complications of pregnancy? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Are you pregnant? If "yes," due date: ___/___/___ . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past 10 years (5 years in IN, KS, and MN), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME, excluding HIV) . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <small>A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets, and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies, and sources of blood loss.)</small> |                          |                          |                          |
| 6. During the past 10 years (5 years in IN, KS, and MN), have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test, or other diagnostic test? (In Maine, excluding HIV) . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. During the past 10 years (5 years in IN, KS, and MN), have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor, or other practitioner, clinic, or hospital? (in ME, excluding HIV) . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. During the past 10 years (5 years in IN, KS, and MN) have you:  |                          |                          |                          |
| a. sought, been advised to seek, or received counseling or treatment for the use of alcohol? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received counseling or treatment for the use of prescribed or non-prescribed drugs; or been arrested for the possession of or use of prescribed or non-prescribed drugs? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ? (in ME, excluding HIV). . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. <b>[If you are a resident of CA, CO, ME, ND, NJ, or WI do not answer question 10.]</b> During the past 10 years (5 years in IN, KS, and MN) have you tested positive for the presence of the Human Immunodeficiency Virus ("HIV") or HIV antibodies? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet, or transferring? . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. During the past 10 years (5 years in IN, KS, and MN) have you used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. During the past 10 years (5 years in IN, KS, and MN) have you had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application? (In ME, excluding HIV) . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Medical Details** (Please provide details if you answered "YES" to any item in the Member/Spouse Statement of Health Section.)  
If you need more space, attach separate sheet with additional information.

Question Letter/No.	Member or Spouse	Reason/Condition	Diagnosis/Treatment/Results	Name, Address & Phone # of Physician and/or Hospital	Date of Onset	Date Last Seen	# of Days Lost from Work

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**Fraud Notice:**

**The following Notice applies to residents of NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**The following Notice applies to residents of NY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

**The following Notice applies to residents of AR, LA, MN, NM, VA, and WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, civil and criminal penalties.

**The following Notice applies to residents of all other states:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

**Agreement and Authorization:**

I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that, subject to the policy's Deferred Effective Date provisions, coverage will not become effective until Unimerica Insurance Company ("Unimerica") grants its underwriting approval. I understand that any condition which is excluded under the Policy will not be covered at any time.

I understand that any pre-existing condition (including any injury, sickness, mental illness, or substance abuse) for which: (a) I was diagnosed or received treatment from a physician or other licensed practitioner of the healing arts; or (b) I took any drugs or medications within the 6 month period prior to my effective date of insurance, will not be covered until the earlier of: (1) the date I have been insured under the policy for 12 months after my Effective Date; or (2) the date I have been free of treatment for such condition for a one-year period ending on or after my Effective Date. Except in ID, ME, and MO, I further understand that pre-existing conditions include any symptoms or subjective symptoms that I had within the 3 month period prior to my Effective Date.

I hereby authorize Unimerica to give information about me to any organization administering the coverage for which I am applying or as required by law. I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, to give Unimerica and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance.

I understand that I may revoke this authorization at any time by sending a written revocation to Unimerica at the address below. Such revocation will not affect any action taken or information released prior to the revocation and will not affect any legal right Unimerica has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke this authorization, Unimerica may not be able to process my application and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws.

I agree that a photocopy of this form shall be as valid as the original and that it shall be valid for 24 months from the date signed.

I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation.

I also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

Member's Signature **X** \_\_\_\_\_ Date **X** \_\_\_\_\_

Spouse's Signature **X** \_\_\_\_\_ Date **X** \_\_\_\_\_

The following additional notice applies only to residents of Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS/ARC. Residents of Maine should also note that failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

**Retain a photocopy of this application for your records and return the original to: Pearl Insurance**

**Be Sure To Complete All Pages and Sign Last Page**  
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