

FRAUD: Any person who, knowingly and with intent to injure, defraud, or deceive any insured files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Check if replacing or changing existing coverage in this company. Policy Number _____

PERSONS PROPOSED FOR INSURANCE									
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.	
			Primary Insured	/ /				- -	
			Spouse	/ /					
			Child	/ /				COMPLETE SHADED	
			Child	/ /				AREAS IF AVAILABLE	
			Child	/ /					
Address			City		State	Zip		Home Telephone ()	
Secondary Addressee			City		State	Zip		Home Telephone ()	
Employer			Date Employed			Hours Worked/Wk			
Occupation		Monthly Income \$		Group Number			Employee/Payroll Number		
Payor or Owner if other than Primary Insured			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security No. - -			Relationship To Primary Insured		
Beneficiary						Age	Relationship		

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? ___Yes ___No. If "No", explain: _____

USED TOBACCO in the past 12 months? Primary Insured ___Yes ___No Spouse ___Yes ___No

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ___Yes ___No. If "Yes", complete replacement form where required.

INSURANCE PLANS										Monthly Premium	
DISABILITY Primary Insured Only			Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here				
<input type="checkbox"/> HPDI2002	Occ. Class	Injury	\$ _____								
<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2	Sickness	\$ _____			<input type="checkbox"/>					
RIDERS	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.				
	Primary Ins.	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____			
	Spouse	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____			
	Children	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		\$ _____	
HOSPITAL			Base Policy	AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.		
<input type="checkbox"/> 0/0	180 Primary Ins.	\$ _____	<input type="checkbox"/> _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
<input type="checkbox"/> 0/0	365 Spouse	\$ _____	<input type="checkbox"/> _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
<input type="checkbox"/> 0/3	365 Children	\$ _____	<input type="checkbox"/> _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
RIDERS	Private Nurse	Surgical+	Spec. Inj.	1st Hosp. Conf.							
	Primary Ins.	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					
	Spouse	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					
	Children	\$ _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____					\$ _____
CANCER			Surgical	Physician Att.	ICU	<input type="checkbox"/> Comp. Care First Occurrence		Disability Income \$500 (Primary Ins. Only)			
Base Policy	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	<input type="checkbox"/> \$500		<input type="checkbox"/> 6 Month Benefit			
<input type="checkbox"/> Primary Ins.	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> \$1000		<input type="checkbox"/> 1 Yr Benefit		\$ _____	
<input type="checkbox"/> Family	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		<input type="checkbox"/> _____		\$ _____	
LUMP SUM CANCER			<input type="checkbox"/> Individual	<input type="checkbox"/> 1 Parent	<input type="checkbox"/> 2 Parent	<input type="checkbox"/> Increasing Spouse Benefit Rider					
			<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000			\$ _____	
LIFE			<input type="checkbox"/> LPRT2002	Amount \$ _____	<input type="checkbox"/> Accidental Death Rider		<input type="checkbox"/> Waiver of Premium				
			<input type="checkbox"/> _____	Units Family Rider	_____ Units Children's Rider	<input type="checkbox"/> Other _____					
			<input type="checkbox"/> Opt A	<input type="checkbox"/> Opt B						\$ _____	

I. HAS ANY PROPOSED INSURED:

- A) Ever tested positive for exposure to the HIV infection, or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ___Yes ___No.
 - B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? ___Yes ___No.
 - C) In the past 2 years had a driver's license suspended/revoked? ___Yes(License # _____ State _____) ___No.
- 2. IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? ___Yes ___No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

D1. FOR DISABILITY COVERAGE: List the amount of any other individual disability insurance currently applied for or in force for the primary insured \$ _____

C1. FOR CANCER COVERAGE: Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? ___Yes ___No

L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:

- A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? ___Yes ___No
- B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? ___Yes ___No
- C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor? ___Yes ___No

Details of "Yes" Answers in 1,D1,C1 or L1. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Insurance Information Practices: This notice describes the practices we, Professional Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

Agreement: I have read, or had read to me the completed application and agree that 1) all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8) no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

Home Office Corrections and/or Additions Only

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X _____ Signed at _____ on ____/____/20____
Signature of Primary Insured City, State Date
 (Parent if person to be insured is less than 15 years old)

X _____ X _____
Signature of Owner (If other than Primary Insured) **Spouse**

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement is is not involved at this time.

X _____/____/20____ _____% _____%
 Signature of Agent Date Agent's No. % Credit State ID No.

Agent's Name (printed)