



Application for CDA-endorsed Group Business Overhead Expense Insurance

Underwritten by The United States Life Insurance Company in the City of New York

(Please Print)

Association: California Dental Association Member # _____

Applicant's Full Name: _____

Birth Date ____ / ____ / ____ Height: ____ feet ____ inches Weight: ____ Sex: ____

Place of Birth: _____

Social Security Number: _____ - _____ - _____

Practice Name: _____

Practice Address: _____

Billing Address(if different): _____

Phone(office): _____ Fax: _____

Email: _____

Beneficiary Name: _____

Relationship to you: _____

Applicant's Profession: Dentistry Annual gross income \$ _____

Are you now, and have you been for the last 30 days, performing the full-time duties of your occupation for at least 20 hours per week with your present employer? Yes No

If no, please explain: _____

Is this a new request or an increase to your present benefits?
 New Increase

Insurance Plan Desired
 Business Overhead Expense Insurance

Maximum benefit period
 24 Months

Benefit Requested
 (\$500-\$25k in \$100 increments)

Monthly benefit: \$ _____
 (not to exceed the amount of monthly expenses actually incurred)

Type of Business:
 Proprietorship
 Corporation
 Partnership

If Corporation or Partnership, my share of the eligible expenses are: _____

Number of years practice has been in existence? _____

Number of full-time employees? _____

INSURABILITY QUESTIONS

- Have you ever had or been treated for: (Circle specific disorders experienced.)
 - Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? .. Yes No
 - Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes No
 - Arthritis, gout, bursitis or rheumatism? Yes No
 - Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? Yes No
 - Disease or disorder of rectum or anus? Varicose veins or other vascular disorder? Yes No
 - Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? Yes No
 - Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? Yes No
 - Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection? .. Yes No
 - Menstrual, uterine or ovarian disorder? Disorder of the breast? Yes No
 - Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose? Yes No
 - Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes No
 - Mental or emotional problem requiring help of a physician or psychologist? Yes No
 - A surgical operation? A surgical operation advised but not performed? Yes No
- Have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner with in the past 5 years? Yes No
Use a separate sheet of paper, sign and date it, if more space is needed to answer the following questions:
- Do you have any Business Overhead Expense insurance in force? Yes No
 If YES, please indicate companies _____
 and amounts _____
- Will this coverage applied for replace any Business Overhead insurance now in force? Yes No
 If YES, please indicate which insurance _____



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 Continued from front side of application
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Give details of any "yes" answer from the reverse side for questions 1 or 2

Question No.	Name of Person	Condition	Date Occurred	Duration	Degree of Recovery	Name, Address and Phone No. of Attending Physician and Hospital

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid transmission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.

I understand that this information will be used by United States Life solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand that this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete.

I understand that my application for insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a policy is issued based on this application and the first premium is paid in full while there is no change in the insurability or health of such person from that stated in the application.

Important Notice — Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

Please make sure to answer the final question at the bottom of this page.

CDA Member's Signature
 G-19025

Date

BOE Group Policy No. G610,244

AG-7074

Please complete this application and return it today!

STATEMENT OF AVERAGE MONTHLY EXPENSE

"What was the average monthly expense incurred by you during the past 6 months in the conduct and operation of your office (excluding your salary, the salary of any other dentists, cost of equipment or goods, and payments on principal of any debt other than a mortgage on the office property)? \$_____."

Mail your application to:
 Attention: New Business Team
 TDIC Insurance Solutions
 1201 K St. Mall, 17th Floor
 Sacramento, CA 95814

or Fax to:
 916.498.6104

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE

(Retain for your records)

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is:

50 Braintree Hill Park
Suite 400
Braintree, Massachusetts 02184-8734.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.