Office Overhead Expense Insurance

With office overhead expense (OOE) insurance, you can help protect your practice and your employees in the event you suffer a disabling injury or illness.

Office Overhead Expense Insurance

Running your practice is expensive. Employee salaries, rent, taxes, utilities—the bills can add up quickly if you're disabled and can't work. With Office Overhead Expense Insurance, you can help protect your practice and your employees.

Office Overhead Expense Insurance is available to TMA members under age 65 with a full-time practice, including physicians with limited medical practice and prospective members.

Office Overhead Expense Insurance Helps You

When you're disabled. If you're disabled and can't work, Office Overhead Expense Insurance pays your actual overhead expenses, up to the benefit amount you select. And you can receive benefits even if you're partially disabled and your income suffers. During disability, your coverage is continued at no cost to you. TMAIT's plan covers you 24/7, and you don't have to be permanently disabled or confined at home or a hospital to receive benefits.

With tax-deductible payments. Your Office Overhead Expense Insurance premium payments may be deductible when filing your federal income tax. As a business expense, your payments fall under IRS ruling 55-264, IRB 1955-19, page 8. You should consult your tax advisor regarding this deduction.

If you leave Texas. If you leave Texas, you can continue your coverage as an Affiliate Member until you reach age 70.

When your survivors need support. If you die while receiving benefits, your spouse or dependent children will receive a single lump sum benefit equal to three times your monthly benefit amount. If less than three months remain in your 24 month benefit period, the payment will be pro-rated.

Know Your Needs

If you don't know how much Office Overhead Expense Insurance you need, use this worksheet to find out. If your practice is a professional corporation or a partnership, only list your portion of the expenses.

Monthly Expense Worksheet

Expense	Amount
Rent or mortgage	$ ________
Employee salaries	$ ________
Employee benefits	$ ________
Depreciation	$ ________
Property taxes	$ ________
Loan interest	$ ________
License fees	$ ________
Office insurance (including malpractice)	$ ________
Accountant fees	$ ________
Ongoing educational programs	$ ________
Professional membership dues	$ ________
Business seminars (including travel expenses)	$ ________
Electricity	$ ________
Heat	$ ________
Water	$ ________
Laundry	$ ________
Telephone	$ ________
Answering service	$ ________
Office equipment and leases	$ ________
Depreciation of equipment	$ ________
Computer network and data access fees	$ ________
Office supplies	$ ________
Other fixed expenses	$ ________
Total	$ ________
Minus estimated overhead reduction during disability*	— $ ________
Monthly Benefit Needed	$ ________

*If you can reduce any expenses during disability without impacting your business, you may want to subtract this amount when calculating your insurance needs.

Choose Your Coverage Amount

Get the coverage amount that's right for you—up to $20,000 a month, in increments of $100. Benefits begin after you have been totally disabled for 30 continuous days and are retroactive to the first day of your disability. Your benefits can continue for as long as 24 months for each period of disability. If you are continuously disabled for more than 24 months but have not yet reached the aggregate amount (equal to your monthly benefit amount multiplied by 24 months), benefits can continue until the aggregate is reached or for 12 months, whichever occurs first. Your coverage ends on the November 1st after you turn 70.

You are totally disabled if you can't perform the material and substantial duties of your occupation due to sickness or injury. You must be under the care of another licensed physician, and you can't be engaged in any other gainful occupation.

Calculate Your Costs

Use the chart below to calculate your quarterly premium. The maximum monthly benefit amount is $20,000. Premiums are paid quarterly and are due on the 1st of February, May, August, and November.

Your Quarterly Costs

Rates are effective 2/1/2002. TMAIT may adjust these rates.

Age	Cost per $1,000 of coverage
Under 30	$ 7
30-39	$ 9
40-44	$ 12
45-49	$ 16
50-54	$ 21
55-59	$ 24
60-64	$ 37
65-69*	$ 39

*Coverage ends on the November 1st following your 70th birthday.

The TMAIT Office Overhead Insurance plan contains exclusions that describe conditions under which benefits are not payable. Refer to the Group Contract for complete details regarding exclusions and reductions.

Prudential Financial

TEXAS MEDICAL ASSOCIATION
INSURANCE TRUST

MEMBER INFORMATION *(Please print in black ink or type all information.)*

Group Policy No. 82750

Name: Last	First	Middle	Height	Weight	Sex
			Ft. In.	Lbs.	☐ M ☐ F

Home Address: Street	City	State	ZIP Code

Birth Date: Month/Day/Year	Place of Birth: City/State	Home Phone
/ /		( )

Billing Address (If different from home): Street	City	State	ZIP Code

Social Security Number	Specialty	Business Phone
		( )

Texas Medical Association Member: ☐ **Non-Member:** ☐

Current Texas Medical License Number:________________________ Texas Medical Association Membership Number:________________________

Are You: ☐ A New Applicant ☐ Increasing Present Coverage

If you are increasing coverage in force, your present amount plus additional amount equals the amount you indicate. (If you do not qualify for the increased amount, your present amount remains in force.)

LONG TERM DISABILITY INSURANCE *(This election requires you to provide a completed Evidence of Insurability form.)*

Please complete the following to determine the total amount of benefits you are eligible to apply for:

- Total monthly benefit desired: (a) $________________
- Total monthly (net) income from the practice of medicine: (b) $________________
- Calculate 66% of monthly income (to nearest $1,000): (b) x.66 = (c) $________________
- Indicate amount of any other monthly disability benefit currently in force: (d) $________________
- Calculate amount of additional coverage needed to equal 66%: (c) – (d) = (e) $________________
- Will TMAIT coverage replace any other company's coverage? ☐ Yes ☐ No If yes, enter amount: (f) $________________
- Add (e) and (f) to determine total coverage available: = (g) $________________

You are eligible to apply for up to the amount of coverage shown in (g). The amount of coverage requested from TMAIT cannot exceed $15,000 per month (the minimum amount is $1,000).

Select One: ☐ **Option 1:** 2-Year Own Specialty Plan ☐ **Option 2:** Catastrophic Plan

Your total monthly benefit may be allocated among the waiting periods in units of $1,000. (If your total amount exceeds $7,000, additional amounts must be under Plan C or D.)

Plan	Waiting Period	Monthly Benefit
☐ A (2-Year Own Specialty Plan only)	30 Days	$________________
☐ B	90 Days	$________________
☐ C	180 Days	$________________
☐ D	365 Days	$________________

Include Cost of Living Adjustment Provision: ☐ Yes ☐ No

Note: The amount selected, if greater than $2,000, together with all other disability in force, may not exceed 66% of the total net income of the physician from the practice of medicine for the calendar year immediately preceding the year in which an application for benefits is made. That total net income must have been included by the physician on his/her most recently filed Form 1040 U.S. Individual Income Tax Return for that calendar year as wages or salaries, as business income on Schedule C, and/or as partnership distributions on Schedule E. The maximum monthly benefit available from TMAIT is $15,000.

TERM LIFE INSURANCE *(This election requires you to provide a completed Evidence of Insurability form.)*

Amount of coverage desired:

Member: ☐ $200,000 ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ Other ______________

Spouse: ☐ $200,000 ☐ $500,000 ☐ Other ________ **Children:** ☐ $5,000 ☐ $10,000

(Spouse coverage may not exceed 50% of the Member amount, up to a maximum of $1,000,000.)

Member's Beneficiary Designation: Name: ________________________________ Relationship:__________________________

Beneficiary's Social Security Number: ___________–___________–___________

If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiaries (or beneficiary) as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Policy.

Additional Beneficiary Designation: Name: ________________________________ Relationship:__________________________

PERSONAL ACCIDENT INSURANCE

Amount of coverage desired: (The maximum for physicians age 60 and over is $100,000)

Member: $________________ (in increments of $10,000, up to a maximum of $1,000,000) **Spouse:** $________________ (in increments of $10,000, up to a maximum of $500,000) (Spouse's amount may not exceed member's amount.)	**Children:** $____________________ (increments of $5,000, up to a maximum of $30,000 each)

Member's Beneficiary Designation: Name: ________________________________ Relationship:__________________________

Beneficiary's Social Security Number: ___________–___________–___________

If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiaries (or beneficiary) as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Policy.

Additional Beneficiary Designation: Name: ________________________________ Relationship:__________________________

OFFICE OVERHEAD EXPENSE INSURANCE *(This election requires you to provide a completed Evidence of Insurability form.)*

Average monthly overhead expense for the last six months: $______________________________________

Monthly Benefit Desired: $______________ *(Member may apply for increments of $100 up to $20,000. Payment will be made on actual expenses only.)*

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating a commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

In order to be eligible for and maintain the insurance indicated above: (a) I am a member of the Texas Medical Association, (b) I must continue such membership to keep this insurance in force, (c) I must be actively at work on a full-time basis on the effective date of coverage, (d) I hereby request participation in the Texas Medical Association Insurance Trust and agree to be bound by its terms, and (e) I will remit required contributions for such insurance when due.

Signature of Member: X____ Date: __________________________

Signature of Spouse: X____ Date: __________________________

Send your completed application in the postage paid envelope provided to: Texas Medical Association Insurance Trust, P.O. Box 1707, Austin, TX 78767-1707

Please do not enclose payment now. You will be billed when notified of your effective date. For questions, call toll free: 800-880-8181, Dept. 870F. Weekdays between 7:30 a.m. and 5:30 p.m.

The Long Term Disability Group Insurance Plan, Term Life Group Insurance Plan, Office Overhead Expense Group Insurance Plan, and Personal Accident Group Insurance Plan are issued by The Prudential Insurance Company of America, 751 Broad St., Newark, NJ 07102. Please refer to your Booklet-Certificate for all plan details, including any exclusions, limitations and restrictions, which may apply. Contract Series: 83500. Prudential Financial and the Rock logo are registered servicemarks of The Prudential Insurance Company of America and its affiliates.

Prudential Financial

Employer Name: Texas Medical Association Insurance Trust

Group Contract No: 82750

Instructions for Member (Complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
  a) Member coverage only–Complete Sections 1, 2, 4, and 5.
  b) Dependent coverage only–Complete Sections 1, 3, 4, and 5.
  c) Member and Dependent coverage–Complete all sections of this form.
  (Note: Evidence of insurability is not required for children.)

2. Please complete the form in blue or black ink. Sign and date Sections 4 and 5.

3. Please read and tear off the important Medical Information Notice that accompanies these instructions and retain for your records. Please retain a copy of your completed application for your own records.

4. Mail the completed form to:

Customer Service Manager
Mail Stop: LDEOI
TMAIT
401 W. 15th Street, Suite 600
Austin, TX 78767

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependent do not answer all questions on the form, if you do not give complete details for any answers requiring details, or if you do not provide complete names and addresses of doctors and hospitals.

NOTE: Coverage is not effective until this request has been approved. You will be notified whether or not coverage has been approved.

If you have questions regarding the completion of this form, please contact TMAIT Customer Service at 800-880-8181.

Member Information

Section 1

1. Member First Name MI Last Name

2. Member Social Security Number ___ – __ – ____

3. Member Phone Number

Daytime ___ ___ – ____

Evening ___ ___ – ____

4. Street Apt.

City State ZIP Code _____ – ____

5. E-mail Address

Section 2

6. Date of Birth

month day year

7. Birth Place

city state

8. Sex

☐ Male ☐ Female

9. Height

ft. in.

10. Weight

lbs.

Section 2 (continued)

11. Name and address of current doctor:

Physician First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

12. Are you currently able to perform all the duties of your job? ☐ Yes ☐ No
If "No", provide full details in item 17.

13. Have you **during the last five years:**

a. had any surgery or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes ☐ No ☐
h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

14. **Within the last five years**, have you been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

15. Do you **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

16. Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If "Yes", which product? ____________________ Yes ☐ No ☐

17. What are the full details of all "Yes" answers to each part of 13 through 15? Attach additional pages if needed.

Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began Month Year	Time lost from normal activities	Full recovery (if applicable) Month Year	Print full names, addresses, and telephone numbers of doctors and/or hospitals

Section 3

1. Member's eligible dependent that requires evidence of insurability.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependent (if different from address in Section 1):

3. Is the person named above unable to perform all of the duties of his/her job or home-confined? Yes ☐ No ☐

4. Has the person named above **during the last five years**:
   a. had any surgery or been advised to have surgery and has not done so? Yes ☐ No ☐
   b. been in a hospital, sanitarium, other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
   c. used, or is now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
   d. been treated or counseled for alcoholism? Yes ☐ No ☐
   e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
   f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
   g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes ☐ No ☐
   h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

5. **Within the last five years**, has the person named above been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

6. Does the person named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or is he/she currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

7. What are the full details of all "Yes" answers to each part of 3 through 6 above? Attach additional pages if needed.

Dependent's Name	Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began Month Year	Time lost from normal activities	Full recovery (if applicable) Month Year	Print full names, addresses, and telephone numbers of doctors and/or hospitals

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may reveal this information, as necessary, to a doctor, if we find a serious health problem which you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the 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. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. 617-426-3660.

It is required that you be given this notice.
Please read it carefully, and keep it for your records.

Section 4

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he/she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

____ ____________________

Signature of Member Date

Section 5 — AUTHORIZATION For the Release of Information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, (2) any insurance company or health maintenance organization (or similar type organization or institution), and (3) the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the Medical Information Bureau. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photocopy of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

____ ____________________

Signature of Member Member Social Security No. Date

____ ____________________

Signature of Spouse (if applicable) Date

Prudential Financial is a service mark of The Prudential Insurance Company of America, Newark, NJ, and affiliates.

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19101

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

Please keep this notice for your records.