

The Prudential Insurance Company of America

TEXAS MEDICAL ASSOCIATION INSURANCE TRUST

Long Term Disability Coverage Request Form *(Please print in black ink)*

Group Contract No: 82750

Please mail your completed Form to TMAIT, P.O. Box 1707, Austin, TX 78767-1707.

Do not include payment now. You will be billed when notified of your coverage effective date.

Member Information *(Please print in black ink)*

First Name MI Last Name

Street Apt. City State

ZIP Code - Date of Birth (mm/dd/yyyy) / / / Height ft. in. Weight lbs. Email Address

Gender Male Female Social Security Number - - Daytime Telephone Number - - Evening Telephone Number - -

TMA Member Number Texas Medical License Specialty Current Coverage Amount *(if applicable)* \$

Long Term Disability Income Insurance Now Requested—

Plan Option *(please select one):* 5-Year Own Specialty Plan (Option 1) Catastrophic Plan (Option 2)

Monthly Benefit Amount *(Allocate amounts among Plan(s) in \$1,000 units. If your total amount is over \$7,000, additional amounts must be placed under Plan C or D; your maximum amount can not exceed \$15,000 per month):*

Plan(s):	Waiting Period:	Monthly Benefit Amount:
<input type="checkbox"/> A <i>(5-Year Own Specialty Plan only)</i>	30 days	\$ _____
<input type="checkbox"/> B	90 days	\$ _____
<input type="checkbox"/> C	180 days	\$ _____
<input type="checkbox"/> D	365 days	\$ _____

Include Cost of Living Adjustment Provision? Yes No

***Please Note: You must complete the Earnings Calculation below if you request a Monthly Benefit Amount greater than \$2,000.**

Earnings Calculation:

Monthly Net Income**

x 66 2/3%

Deduct Other Monthly Disability Income Coverage

Total***

Monthly Benefit Amount:	Minimum Monthly Earnings Requirement:
\$ 2,000	no minimum
3,000	\$ 4,505
4,000	6,006
5,000	7,508
6,000	9,009
7,000	10,511
8,000	12,012
9,000	13,514
10,000	15,015
11,000	16,517
12,000	18,018
13,000	19,520
14,000	21,021
15,000	22,523

**Net income from the practice of medicine.

***Your total TMAIT monthly benefit can not exceed this amount.

Payment Basis—Please note: All your TMAIT insurance coverage(s) will be billed per your election below. *(Please check one):*

Bill Me Quarterly Monthly Electronic Funds Transfer (EFT) *

***Monthly Electronic Funds Transfer Authorization**—If you wish to use your checking account, **enclose a blank voided check** for that account. If you wish to use your credit union or savings account, you must confirm that your bank permits electronic funds withdrawals. By my signature below I authorize the Texas Medical Association Insurance Trust in accordance with the Agreement (see the back of the attached letter) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

Checking Savings Credit Union
Type of Account

Account Owner's Name

Bank or Credit Union Name

Bank's Transit Routing Number (9 digits required)

Your Account Number

X
Signature of Account Owner

In order to be eligible to maintain the insurance indicated above, I acknowledge: (a) that I am a member of the Texas Medical Association, (b) that I must continue such membership to keep this insurance in force, (c) that 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: _____

Health Questionnaire (Please print in black ink)

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Within the last 12 months , have you smoked cigarettes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently performing all the duties of your job for the number of hours required?
If no, please explain:..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the last five years have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions: | | |
| a. Disease or disorder of the heart, blood or circulatory system..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cancer or tumors..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Lung, respiratory or breathing disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Liver or kidney disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Mental or nervous illness or disorder, alcoholism or drug addiction..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Chronic pain or fatigue syndromes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome..... | <input type="checkbox"/> | <input type="checkbox"/> |

Within the last five years, have you been diagnosed with or treated by a physician for, Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS) or any other immune deficiency disorder (such as Lupus)?..... Yes No

- 4. Within the last five years**, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?..... Yes No
- 5. Within the last five years**, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?.. Yes No
- 6. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?..... Yes No
- 7. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?.. Yes No

If you answered "Yes" to any of questions 3-7, please provide full details below. (If more space is needed, please attach an additional sheet.)

Question Number and Item Letter	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Date of Illness	Date of Full Recovery	Names, complete addresses and phone numbers of physicians

Primary Care Physician Information

Name _____ Date last seen _____ Telephone _____
 Address _____

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization to release the entire medical record for me, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my knowledge and belief. I understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I also understand that coverage will not take effect if the facts have changed. I have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

X

Member Signature

Date (mm/dd/yyyy)

Electronic Funds Transfer Authorization: Texas Medical Association Insurance Trust Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the first business day of each month. Your first electronic payment will be debited on the first business day of the following month as long as TMAIT receives this authorization form by the 10th of the current month. If the transfer falls on a weekend or bank holiday, your account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

Important Notice: For residents of all states except Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington: 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 commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be 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.

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization to release the entire medical record for me, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

X

Member Signature

Date (mm/dd/yyyy)

Please retain this page for your records.