



INDIANA STATE BAR ASSOCIATION

Serving the legal profession and the public

**ASSOCIATION DISABILITY INSURANCE
THROUGH THE
ISBA INSURANCE AGENCY**

Thank you for your interest in the ISBA Disability Income and Business Overhead Expense Insurance. Per your request, please find the following:

- **A product brochure for individual disability and business overhead expense insurance, including rates**
- **An issue and participation worksheet**
- **An application for individual disability and business overhead expense**
- **Supplemental application for business overhead expense**

If you wish to apply for coverage, please complete the issue & participation worksheet and applications in full and return to: ISBA Insurance Agency, c/o Brown & Brown of Indiana, 11555 N. Meridian Street Ste. 220, Carmel, IN 46032.

Please DO NOT cancel any existing insurance coverage until you are notified of approval and given your effective date. If you have any questions or need assistance, please do not hesitate to contact our association office (317)471-4229 or toll free (877)647-2242, or email: kbrockway@bbindy.com .

Help preserve your lifestyle – and your practice – if disability strikes

A sudden illness or accident that keeps you out of work for an extended period of time can cut off your income – and possibly turn your world upside down. The result could be financial hardship for your family – and for your business.

Your membership in the Indiana State Bar Association (ISBA) entitles you to apply for both a Disability Income and a Business Overhead Expense insurance plan that would provide you with benefits to pay many of your business' expenses should a covered disability strike. One or both of these plans could be just what you need to help your family and your business make it through a health crisis.

You are eligible to apply for either or both plans if you are a member of the ISBA and are actively in practice for at least 30 hours per week. You may choose to pay premiums either annually or semi-annually. Premiums are step-rated based on attained age.

DISABILITY INCOME AND BUSINESS OVERHEAD EXPENSE INSURANCE FOR MEMBERS OF THE INDIANA STATE BAR ASSOCIATION

This insurance can help keep you and your business on steady financial ground if you are unable to work for a time due to an unexpected injury or illness.

Acceptance is subject to evidence of insurability as determined by the underwriting company. You must be actively at work on the date insurance is to take effect. If not, it will take effect on the date you return to work.

Exclusions: Disability Income Insurance and Business Overhead Expense Insurance policies do not cover any loss or disability caused by or contributed to by: suicide or attempted suicide, while sane or insane (in Missouri, while sane); intentionally self-inflicted injury; war or act of war, whether declared or undeclared; service in the armed forces of any country or authority (in such event, the pro rata unearned premium will be returned to you); traveling in or flying any aircraft operated by or under the direction of any military authority (land, sea or air) or while in any aircraft being used for any test or experimental purpose; participation in the commission or attempted commission of a felony. Limited benefits are paid for mental or nervous disorders, alcoholism and drug addiction. Continuous disability due to normal pregnancy or childbirth will be covered provided the pregnancy commences at least 30 days after your effective date.

Policyholders are not entitled to benefits for two periods of disabilities at one time. In addition, no benefits will be payable for any period of total disability during which you are confined in a penal or correctional institution.

Overhead expenses do not include your salary, fees, drawing accounts or any other remuneration for you; salaries, fees, drawing accounts, or any other remuneration for members of your profession who work for or with you; salaries for any members of your family who are not regularly employed by you for at least three months prior to the date of total disability; payments of principal of any debt; the cost of merchandise, equipment, or other supplies pertaining to your profession; income tax; or the cost of leased automobiles.

Termination: The policy will end if premiums are not paid when due, when you attain age 70, when you retire or cease to be actively engaged in the duties of your occupation, except by reason of disability covered under the terms of the policy, if the association no longer exclusively sponsors this plan, or if you cease to be a member of the association.

Important: This brochure is only a brief description of benefits provided under policy number G-300,122(B), form number S-10500-IN (Disability Income) and policy number G-300,037, form number S-10700-IN (Business Overhead Expense) and is subject to the terms, conditions, limitations and exclusions of the respective policies.

Administered by:



Indiana State Bar Association
Insurance Agency

ISBA Insurance Agency
11555 N. Meridian Street, Ste. 220
Carmel, IN 46032
1-877-647-2242
Fax: 317-471-1700

Underwritten by:

American General Assurance Company
Schaumburg, Illinois
www.americangeneral.com

The underwriting risks, financial and contractual obligations and support functions associated with products issued by American General Assurance Company (AGAC) are its responsibility.

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ISBA-DI/BOE

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HELP PROTECT YOUR INCOME – AND YOUR BUSINESS – IF YOU SUDDENLY CAN'T WORK

DISABILITY INCOME
INSURANCE AND
BUSINESS OVERHEAD
EXPENSE INSURANCE
FOR OUR MEMBERS

SPONSORED BY:



Indiana State Bar Association

Disability Income Insurance *helps keep your lifestyle intact if you're unable to work*

No one knows when or how a disabling accident or sickness may strike, but disability income insurance protection like this plan provides could help soften the financial impact, helping you and your family maintain your standard of living during a period of disability.

Select a monthly benefit amount of up to \$10,000, in \$100 increments: If you are a member under age 60, you may apply for up to \$10,000, subject to issue limits and based on your current age:

- Under age 50: up to \$10,000 per month
- Age 50 through 54: up to \$6,000 per month
- Age 55 through 59: up to \$3,000 per month

Benefits are paid regardless of other insurance you may have, with no offsets for Social Security. When you reach age 65 and if you are not disabled, monthly benefits over \$2,200 will be reduced to \$2,200.

Includes “own occupation” protection: The plan pays full benefits up to age 65 if you are totally disabled before age 65 and are completely unable to perform the substantial and material duties of your regular occupation.

Simplified underwriting for amounts up to \$3,000:

The plan features simplified underwriting for a member under age 50 applying for a plan with up to \$3,000 in sickness and injury monthly benefits. Unless required because of your medical history, no medical exams, blood work, tax returns or other underwriting tests will be requested. (Issuance of a Certificate of Insurance or payment of benefits may depend upon the answers given in the application and the truthfulness of those answers.)

Here's how long you can receive benefit payments:

This plan pays accident and sickness benefits for total disability up to age 65 for disabilities that begin prior to age 63. It pays benefits for up to 24 months for disabilities that begin on or after age 63.

A total disability means that due to injury or sickness, you are unable to perform the substantial and material duties of your occupation. You must be receiving regular medical care from a physician.

Plan may continue to pay partial disability benefits:

Benefits are payable for a residual (partial) disability when you are not totally disabled. A residual disability means you suffer an income loss of at least 20% (but less than 50%) and are unable to perform one or more of the substantial and material duties

of your occupation, or are unable to perform them for as much time as is normally required. The benefit is a percentage of your monthly total disability benefit and is equal to the percentage of income loss from the pre-disability earnings.

Select a waiting period that's comfortable for you:

You may choose from a range of waiting periods before your benefit payments would begin: 60, 90 or 180 days. The longer the waiting period, the more economical your premium. To determine your cost for the monthly benefit amount you'd like, please see the enclosed rate chart.

Renewal guaranteed to age 70: Coverage continues as long as you are actively at work and pay your premium when due.

Optional benefit riders are available: With the Cost of Living Adjustment rider, you can have your monthly benefits during any continuous period of total and/or residual disability increased based on the Urban Consumer Price Index, or CPI-U.

If you are under age 40, you can add the Guaranteed Purchase Option rider, which increases your monthly disability benefit by 25 percent of the original amount, without having to provide evidence of insurability, on the second, fourth, sixth and eighth anniversaries of the renewal date.

Business Overhead Expense Insurance *helps keep your business up and running*

Overhead expenses don't stop just because you are unable to work for a time. This plan can provide valuable insurance protection for you and your business by providing benefits to help you pay many of your business' expenses should you become totally disabled due to injury or sickness.

Apply for a benefit of up to \$10,000 per month, in \$100 increments: If you're under age 55, you can apply for up to \$10,000 per month, subject to issue and participation guidelines.

Accident and sickness benefits are payable to a maximum benefit period of 24 months per occurrence. Plan features and benefits will remain the same for the lifetime of the policy; coverage terminates when you reach age 70.

This coverage helps pay your overhead expenses for up to 24 months:

Many of your business expenses are covered, including:

- Office rent, office equipment rental and utility bills
- Employees' salaries and insurance plans
- Insurance premiums for the office (including professional malpractice insurance)
- Accountants' services and professional association dues
- Laundry
- Depreciation and other fixed overhead expenses

The plan offers “own occupation” benefits and a waiver of premium provision if you become totally disabled before age 60 and remain so for six continuous months.

Choose your waiting period: Select either a 15- or 30-day waiting period before benefit payments begin. After the waiting period has been satisfied, benefits are paid retroactive to the first day of disability.

Premiums are normally a tax-deductible business expense. (Consult your tax advisor.)

**BUSINESS OVERHEAD EXPENSE INSURANCE
SEMI-ANNUAL PREMIUMS PER MONTHLY BENEFIT SHOWN
(30-DAY WAITING PERIOD)**

	ATTAINED AGE				
	UNDER 30	30-39	40-49	50-59*	60-69*
\$ 2,000	\$ 36.00	\$ 56.00	\$ 96.00	\$176.00	\$ 376.00
\$ 4,000	72.00	112.00	192.00	352.00	752.00
\$ 6,000	108.00	168.00	288.00	528.00	1,128.00
\$ 8,000	144.00	224.00	384.00	704.00	1,504.00
\$10,000	180.00	280.00	480.00	880.00	1,880.00

**55-69 for renewal purposes only.*

Coverage ends upon attainment of age 70.

A \$3.00 administrative fee will be added to your premium bill.

Don't wait to start helping to protect your income and your business. Fill out and return your application today!

Send no money now – we'll send you a premium notice upon approval.

If you have any questions, please contact us at 1-877-647-2242.



DISABILITY RATE CHART

INDIANA STATE BAR ASSOCIATION

ECONOMICAL SEMI-ANNUAL PREMIUMS (INCLUDING RESIDUAL BENEFITS)

Your association membership makes you eligible to apply for Disability Income Insurance at economical group rates. Please review the Disability Income Insurance details in the accompanying brochure. Then find your group cost below based on your preferred monthly benefit amount and waiting period.

Monthly Benefit \$1,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 61.80	\$ 50.90	\$ 46.40
30-39	86.15	71.25	64.90
40-49	141.90	117.40	106.85
50-59	228.70	189.10	172.05
60-64*	233.55	188.25	155.20
65-69*	212.25	166.70	137.70

Monthly Benefit \$2,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 122.60	\$ 100.80	\$ 91.75
30-39	171.35	141.50	128.85
40-49	282.80	233.85	212.65
50-59	456.45	377.25	343.10
60-64*	466.10	375.50	309.40
65-69*	423.50	332.35	274.40

Monthly Benefit \$3,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 183.40	\$ 150.75	\$ 137.10
30-39	256.50	211.75	192.75
40-49	423.70	350.25	318.45
50-59	684.15	565.35	514.15
60-64*	698.60	562.75	463.60
65-69*	465.75	365.50	301.70

Monthly Benefit \$4,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 244.25	\$ 200.65	\$ 182.50
30-39	341.65	282.00	256.65
40-49	564.55	466.65	424.30
50-59	911.85	753.45	685.15
60-64*	931.15	750.95	617.75
65-69*	465.75	365.50	301.70

Monthly Benefit \$5,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 305.05	\$ 250.55	\$ 227.85
30-39	426.80	352.25	320.55
40-49	705.45	583.05	530.10
50-59	1,139.55	941.55	856.20
60-64*	1,163.70	937.20	771.95
65-69*	465.75	365.50	301.70

Monthly Benefit \$6,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 365.85	\$ 300.45	\$ 273.25
30-39	511.95	422.50	384.45
40-49	846.35	699.45	635.90
50-59	1,367.25	1,129.65	1,027.25
60-64*	1,396.25	1,125.45	926.15
65-69*	465.75	365.50	301.70

Monthly Benefit \$7,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 426.65	\$ 350.35	\$ 318.60
30-39	597.15	492.75	448.40
40-49	987.25	815.90	741.75
50-59	1,594.95	1,317.80	1,198.30
60-64*	1,628.75	1,312.70	1,080.35
65-69*	465.75	365.50	301.70

Monthly Benefit \$8,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 487.45	\$ 400.25	\$ 363.95
30-39	682.30	563.00	512.30
40-49	1,128.10	932.30	847.55
50-59	1,822.70	1,505.90	1,369.30
60-64*	1,861.30	1,499.95	1,234.50
65-69*	465.75	365.50	301.70

Monthly Benefit \$9,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 548.25	\$ 450.15	\$ 409.35
30-39	767.45	633.25	576.20
40-49	1,269.00	1,048.70	953.35
50-59	2,050.40	1,694.00	1,540.35
60-64*	2,093.85	1,687.15	1,388.70
65-69*	465.75	365.50	301.70

Monthly Benefit \$10,000			
Attained Age	Waiting Period		
	60 Days	90 Days	180 Days
To 30	\$ 609.05	\$ 500.05	\$ 454.70
30-39	852.60	703.50	640.10
40-49	1,409.90	1,165.10	1,059.20
50-59	2,278.10	1,882.10	1,711.40
60-64*	2,326.35	1,873.40	1,542.90
65-69*	465.75	365.50	301.70

Apply now for this special member offer.

Just complete, sign and date the enclosed application today, and mail it in the postage-paid envelope provided.

Coverage terminates when you reach age 70. Monthly benefits in excess of \$2,200 are reduced to \$2,200 when you reach age 65 if you are not disabled. Rates include \$1.00 for the included Accidental Death and Dismemberment coverage. A \$3.00 administrative fee will be added to your premium bill.

*Rates for ages 60-69 are for renewal only.

This is a brief description of coverage provided under group policy number G-300,122(B), Form No. S-10500-IN, and is subject to the terms, conditions, limitations and exclusions of the policy.

10-day free look

If you change your mind, you can return your policy within 10 days of receipt and obtain a full refund of any premium you have paid.

Questions? Call 1-877-647-2242.

Administered by:

ISBA Insurance Agency
11555 N. Meridian Street, Ste. 220
Carmel, IN 46032
1-877-647-2242, Fax: 317-471-1700

Underwritten by:

American General Assurance Company
Schaumburg, Illinois

www.americangeneral.com

ISBA Disability Insurance Issue & Participation Worksheet

- 1) Your total monthly disability (including all coverage's individual, group LTD, and this new plan) cannot exceed 100% of your gross monthly income.
- 2) Issued monthly benefits will not exceed age:
 50 and under - \$10,000 50-54 - \$6,000 55-59 - \$3,000
- 3) The maximum monthly benefit you can purchase from the ISBA disability plan is \$10,000. But cannot exceed the maximum benefit based on income from the chart at the bottom of this page.

Please complete the following worksheet to determine the monthly benefit you are eligible for.

- A. Find your maximum monthly benefit based on annual \$_____A earnings from the table below.
- B. Current Individual Disability Insurance Monthly Benefit \$_____B (if any)
- C. 75 % of Current Group LTD Disability Monthly Benefit , \$_____C (provided by practice)
- D. Add any other coverage through American General(ABA) \$_____D
- E. Add lines B, C and D to determine total current disability benefit \$_____E
- F. Subtract line E from line A to determine the maximum monthly benefit. You are eligible for under the ISBA Disability Plan
 (Not to exceed \$10,000, see table below) \$_____F

ISBA DISABILITY/UNITED STATES LIFE ISSUE & PATRICIPATION TABLE

Annual Earnings	Maximum Monthly Benefit	Annual Earnings	Maximum Monthly Benefit
\$ 50,000	\$2,900	\$160,000	\$ 8,700
60,000	3,500	170,000	9,300
70,000	4,100	180,000	9,600
80,000	4,650	190,000	10,000
90,000	5,250	200,000	10,400
100,000	5,800	225,000	11,400
110,000	6,300	250,000	12,400
120,000	6,800	275,000	13,500
130,000	7,500	300,000	14,500
140,000	7,800	400,000	15,000
150,000	8,300	500,000	15,000

- 1) Applications:
 \$3,000 and less NO blood, Urine specimen: (Underwriting may request later)
 \$3,000 + Blood, Urine and Paramed
 Underwriting: Accept or Decline – No Ratings – Will Rider (exclusions)
 Income Tax verification will be needed for benefits of \$6,000 or more



APPLICATION FOR DISABILITY INCOME AND BUSINESS OVERHEAD EXPENSE INSURANCE For members of the Indiana State Bar Association

PERSONAL INFORMATION

Name: Social Security Number: Practice Name: Home Telephone No.: Billing Address: Business Telephone No.: Fax Number: E-mail:

Please fill in your Daytime Phone Number to assist us in contacting you should the need arise in processing your application: ()

Occupation:

Are you now working at least 30 hours per week with your present employer? Yes No

Beneficiary Name:

Relationship To You:

I wish to pay premiums: Annually Semi-Annually

(Send no money now - we'll send you a premium notice upon approval.)

I WOULD LIKE TO APPLY FOR DISABILITY INCOME INSURANCE

My annual earned income for the 12 months immediately preceding the date of this application is: \$

Indicate the monthly benefit desired (in \$100 increments): \$

Indicate Waiting Period (check only one):

60 Day 90 Day 180 Day

Maximum Benefit Period: To age 65

Optional Riders (Check if desired):

Cost of Living Rider Guaranteed Purchase Option

AND I WOULD LIKE TO APPLY FOR BUSINESS OVERHEAD EXPENSE INSURANCE

Average monthly amount of eligible expenses in the preceding six months? \$ per month

Type of Organization:

Proprietorship Corporation Partnership

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

Indicate the monthly benefit desired (in \$100 increments): \$

Indicate Waiting Period: 15 day 30 day Benefit Period: 24 month

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Height ft. in. Weight lbs. Sex M F Date of Birth / / Place of Birth

- 1. In the past 5 years, have you ever had or been treated for: (Circle specific disorders experienced) a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? c. Arthritis, gout, bursitis or rheumatism? d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? e. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder? f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? i. Menstrual, uterine, or ovarian disorder, disorder of the breast? j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? l. Mental or emotional problem requiring help of a physician or psychologist? m. A surgical operation? A surgical operation advised but not performed? 2. Have you consulted any hospital, institution, physician, or practitioner within the past five years for any disease, disorder or injury other than stated above?

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE (Retain for your records)

Information regarding your insurability will be treated as confidential. American General Assurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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.

American General Assurance Company, or its reinsurers, may also release information from 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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

APPLICATION FOR DISABILITY INCOME AND BUSINESS OVERHEAD EXPENSE INSURANCE
CONTINUED FROM FRONT SIDE OF APPLICATION
For members of the Indiana State Bar Association

Please print or type all information

If you answered "Yes" to questions 1 a-m or 2, please explain fully in the chart below.
 Should you require additional space, please use a separate sheet of paper, signed and dated, and attach it to this form.

Question Number	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted

What other Disability Insurance or Business Overhead Expense insurance do you now carry or have an application pending for?
 Give Full Details: I-Individual, BOE-Business Overhead, G-Group Long Term Disability (If none, check "None.") None

Type of Coverage	Insurance Company	Amount of Monthly Benefit	How long are benefits payable?	
			Accident	Sickness

Are you replacing any current disability income or business overhead expense coverage you have? Yes No

If "Yes", provide name of Insurance Company and Policy Number: _____

DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

- To the best of my knowledge and belief, all statements made on this application are true and complete.
- I understand that my application for insurance will be accepted or declined on the basis of these statements.

AUTHORIZATION

I authorize the sources stated on the MIB Disclosure to give to American General Assurance Company, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional, any hospital, clinic or other medical care institution; any insurer, the Medical Information Bureau; any consumer reporting agency; any employer. I understand that this information will be used by American General Assurance Company 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 that American General Assurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier. I know that I have the right to receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original.

Fraud Statement — 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 is a crime.

 (Date Signed) (Signature of Proposed Insured)

 (Signature of Agent)

Underwritten by: American General Assurance Company

Just complete this application and return it today!

**Mail your application to: ISBA Insurance Agency, 11555 N. Meridian Street, Ste. 220
 Carmel, IN 46032, 1-877-647-2242, Fax: 317-471-1700**



American General Assurance Company

SUPPLEMENTARY APPLICATION FOR BUSINESS OVERHEAD EXPENSE POLICY

Personal Information

I am a member of the _____ Policy # _____

Name: _____

Company Name: _____

Business Address: _____

Home Address: _____

List the companies and the amounts of Office Overhead Expense Insurance presently in force

Is this insurance intended to replace any insurance in force? Yes No

If yes, please state companies, amounts and date of replacement _____

What is your average monthly office overhead expense? _____

Are any of your office overhead expenses incurred through joint occupancy? Yes No

If yes, what is your percentage of the total expense? _____

List the monthly office overhead expenses which you wish to have covered:

Rent \$ _____ /Month

Utilities \$ _____ /Month

Business premises:

Mortgage interest \$ _____ /Month

Real estate tax \$ _____ /Month

Business equipment:

Mortgage interest \$ _____ /Month

Property tax \$ _____ /Month

Other:

_____ \$ _____ /Month

_____ \$ _____ /Month

_____ \$ _____ /Month

Employees' salaries:

_____ \$ _____ /Month
occupation

_____ \$ _____ /Month
occupation

_____ \$ _____ /Month
occupation

_____ \$ _____ /Month
occupation

_____ \$ _____ /Month
occupation

Total monthly office overhead expense coverage applied for: \$ _____ /Month

I understand that the Company will rely on the above statements in determining the need and justification for the insurance applied for. I attest that all answers are true and accurate statements to the best of my knowledge and belief and are made in continuation of and as part of any application for the above insurance coverage.

Date: _____ Signature of Member: _____

Underwritten by: American General Assurance Company

PLEASE RETURN THE COMPLETED FORM TO:

Plan Administrator • 11555 N. Meridian Street, Ste. 220 • Carmel, IN 46032 • Questions? Call 1-877-647-2242