

# EVEREST REINSURANCE COMPANY

## Application for Disability Insurance Independent Contractors and Self-Employed

**Policy Effective Date:**  
**Application No:**  
**Producer:**

NAME OF INSURED, called You	DATE OF BIRTH	AGE	SEX	INSURED'S EMAIL ADDRESS
INSURED'S ADDRESS		INSURED'S PHONE		MONTHLY SALARY
INSURED'S BUSINESS NAME		OCCUPATION		INDUSTRY
MONTHLY INSURANCE BENEFIT AMOUNT	MAXIMUM BENEFIT PERIOD	PREMIUM MODE		TOTAL ANNUAL PREMIUM

INSURED HAS CHOSEN THE FOLLOWING INSURANCE COVERAGE:

DISABILITY INSURANCE

### EMPLOYMENT QUESTIONS

DO YOUR PRIMARY JOB DUTIES INCLUDE PUSHING, PULLING OR LIFTING 50 POUNDS OR MORE?

YES

NO

INDICATE WHICH OF THE FOLLOWING CATEGORIES ARE INCLUDED IN YOUR PRIMARY JOB DUTIES:

OPERATE LIGHT EQUIPMENT OR MACHINERY (E.G., PALETTE MOVER, HAND CART, ETC...)

OPERATE MEDIUM EQUIPMENT OR MACHINERY (E.G., FORKLIFT, DRILL PRESS, LATHE, ETC...)

OPERATE HEAVY EQUIPMENT OR MACHINERY (E.G., EARTHMOVER, BACKHOE, GRAPPLER, ETC...)

DOES NOT APPLY

### STATEMENT OF THE INSURED

I, the Insured shown above, request to enroll under the insurance coverage provided by Everest Reinsurance Company based on the information shown above.

To the best of my knowledge and belief, the information provided on this application form is true and complete. It is offered to Everest Reinsurance Company as the basis for any insurance issued.

I have read the completed application form and I realize any false statement or misrepresentation may result in loss of coverage under the policy. I understand and agree that if this application form is accepted by the company, coverage will begin on the date of acceptance, subject to the payment of the required premium.

I am Actively at Work for wages or profit as an independent contractor or self-employed and, excluding temporary paid or unpaid absences during which I was still considered an independent contractor or self-employed, of at least 30 hours a week and I have done so for at least                      consecutive days immediately prior to the Policy Effective Date above. I also certify that that at least                      of my Average Monthly Income is derived from my work as an independent contractor or self-employed

I understand that the policy contains certain provisions excluding coverage from situations such as normal pregnancy or when I have been treated by, diagnosed by or consulted with, a licensed Physician or licensed chiropractor for the medical condition in the                      months before the Policy Effective Date and such condition becomes the cause of Disability within                      months after the Policy Effective Date.

I understand that I will receive a policy of insurance describing the terms of my Disability coverage, Insurance Riders and that this application form shall form a part of that Policy. I acknowledge receipt of a copy of this form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\_\_\_\_\_  
Insured Signature

\_\_\_\_\_  
Date