

EVEREST REINSURANCE COMPANY

Application for Disability Insurance - Employee

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 EMPLOYER 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 for my current employer, excluding temporary paid or unpaid absences during which I was still considered an employee, of at least 30 hours per week and I have done so for at least consecutive days immediately prior to the Policy Effective Date above. I also certify that my Monthly Salary, as indicated above does not include any non-regular compensation including but not limited to periodic bonuses or commission-based income.

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_COVERAGE:SIGNATURE]

[INSURED_COVERAGE:SIGNATURE DATE]

Insured Signature

Date