

60 West Gude Drive
 Rockville, Maryland 20850
 (301) 294-6232

LONG TERM DISABILITY
 INCOME INSURANCE APPLICATION

FULL NAME _____
Last Name First Name Middle Initial

MAIL ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____ TELEPHONE _____

WEIGHT _____ HEIGHT _____ SEX _____

DATE OF BIRTH _____ AGE _____
MONTH DAY YEAR

SOCIAL SECURITY NUMBER _____

BENEFICIARY _____

RELATIONSHIP _____

ANNUAL SALARY* _____

OCCUPATION _____

SCHOOL NAME _____ SCHOOL NO. _____

DATE OF EMPLOYMENT _____

I am covered by Social Security. YES NO

I am an active or life member of the NEA, currently employed in the field of education. YES NO

I am currently insured by an American Fidelity Disability Income Plan. YES NO

*The monthly disability benefit may not exceed 66 2/3% of the monthly salary (annual contract salary exclusive of bonus and overtime earnings divided by 12).

To the best of my knowledge and belief, the statements and answers shown above are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract; and b) that no coverage will take effect until a Policy or Certificate is issued.

I authorize any person or organization having records or knowledge of me or my health to give American Fidelity Assurance Company, or its reinsurer(s) such information. Those so authorized include: a) licensed physicians or practitioners; b) hospitals, clinics or medically related facilities; c) insurance companies; or d) the Medical Information Bureau. This authorization will expire two years from the date shown below. A photographic copy of this authorization will be as valid as the original. I understand that the information collected will be used to determine my eligibility for insurance. I am aware that I may receive a copy of this authorization. I have received a copy of the Notice to Applicants for Insurance and the MIB Notice.

I understand that the coverage applied for: a) will take effect only if I am on Active Service on the effective date of my coverage; and (b) may provide limited benefits for "Pre-Existing Conditions." I understand that I should read my Certificate for a more detailed explanation of this "Pre-Existing Condition" exclusion.

PLEASE ANSWER THESE HEALTH QUESTIONS:
 (Answering yes to any of these questions does not necessarily mean you are ineligible to become insured.)

- Have you within the past five years: consulted any physician; or been in the hospital, sanitarium, medical clinic, or other institution for diagnosis and treatment? YES NO
- Have you within the past five years been treated or medically advised that you have or had any of the following disorders:
 - heart trouble; shortness of breath; high blood pressure or other heart or circulatory disorders; albumin, blood or sugar in the urine; diabetes; any kidney or lung disorder; or stomach, intestinal or liver disorder? YES NO
 - epilepsy, apoplexy or any disorder of the brain or nervous system; mental or psychological disorder; blood disorders; acquired immune deficiency; arthritis, bone, joint, back or muscle disorder; cancer; goiter or tumor; reproductive organ dysfunction or disorder; or alcoholism or drug habit? YES NO
- Are you now taking any type of prescribed medication for any reason? YES NO
- Are you now disabled or aware of a condition which will disable you in the next 12 months? YES NO

Give details to all "YES" answers. State below: dates and types of treatment; diagnosis; outcomes; and names and addresses of all attending physicians and medical facilities. If necessary, use a separate sheet of paper, dated and signed. _____

A-958 Signature (Employee) Applicant

Agent Signature

Date

1. PLEASE CHECK THE PLAN YOU PREFER:

PLAN I PLAN IV** PLAN V

**You must have five years or more credit in the state retirement or pension system to be eligible for Plan IV.

2. CHECK MONTHLY BENEFIT AMOUNT DESIRED:

- | | | | | |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> \$800 | <input type="checkbox"/> \$1,100 | <input type="checkbox"/> \$1,400 | <input type="checkbox"/> \$1,700 | <input type="checkbox"/> \$2,000 |
| <input type="checkbox"/> \$900 | <input type="checkbox"/> \$1,200 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$1,800 | <input type="checkbox"/> \$2,500 |
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$1,300 | <input type="checkbox"/> \$1,600 | <input type="checkbox"/> \$1,900 | <input type="checkbox"/> Other |

Thank you for considering American Fidelity Assurance Company in making this application for insurance. It is understood that an Investigative Consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. The inquiry includes information as to your character, general reputation, personal characteristics and mode of living.

You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. American Fidelity Assurance Company or its reinsurers may, however make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates as information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for

benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange to disclose of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02212, telephone number, (617) 426-3360.

American Fidelity Assurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in processing my application or determining my eligibility for coverage for the purpose of determining eligibility in the insurance coverage(s) for which I have applied and to check for and resolve any issues that may arise regarding incomplete or incorrect information on my application. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) consumer reporting agencies; g) insurance companies; h) the Medical Information Bureau (MIB); and i) Department of Motor Vehicles. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Minnesota residents, please be advised that although the law allows insurance companies to obtain information about an HIV test, there are specific instances wherein the insurance company cannot ask whether the person has had an HIV test performed. In those specific circumstances, this law also restricts the use of HIV test results in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate or contract. For Vermont residents, this authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing AFAC to forward the results from any new test requested by AFAC to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services. Nothing in this release authorizes the disclosure of data regarding AIDS, ARC or HIV. For Wisconsin residents, results of AIDS/HIV tests do not need to be reported if they were done at an anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, AFAC may refuse to issue insurance coverage. I understand that I may revoke this authorization at any time by writing to Privacy Official, American Fidelity Assurance Company, PO Box 25523, 2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125, or by calling, toll-free, 1-866-55-HIPAA. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date shown below. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below. A copy of this authorization will be as valid as the original. I am aware that I, or my authorized representative, am entitled to and will receive a copy of this authorization.

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Signature (Applicant) or Personal Representative (if applicable)	Printed Name (Applicant)
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Relationship of Personal Representative to Applicant	SSN (Applicant) Date

