The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102

Contract Holder:
NATIONAL BUSINESS ASSOCIATION FOR CHIROPRACTORS
CN-51653

D.C. Long Term Disability Insurance Request for Coverage Form

Return this completed form with the Payment Information Form to:
NCMIC Insurance Services
14001 University Avenue • Clive, IA 50325
Phone: 1-800-769-2000, ext. 8212 • Fax: 1-800-996-2642

Please print all answers using black ink.

1. Tell us about yourself:

_____ _____ _____
First Name MI Last Name

_____ _____
Address Apt #

_____ _____ _____
City State ZIP code

_____/_____/_____ _____-_____-_____ (_____)_____ Sex: ☐ Male ☐ Female
Date of Birth (mm/dd/yyyy) Social Security Number Daytime Telephone Number

_____ft_____in _____lbs. (_____)_____ _____
Height Weight Fax Number Email Address

My annual earned income for the 12 months immediately preceding the date of this request form is: $_____. *(Annual earned income includes salary, profits, fees, commissions, bonuses, and other compensation for professional services. It does not include investment returns, rent, royalties or other like income not directly produced by your occupation. Earnings are determined after deduction of normal business expenses and losses, but before deduction of any income taxes.)*

2. Select your coverage options:

Monthly Benefit Applied for: $_____ per month. *Monthly benefit amounts available are $500 to $7,500, not to exceed 60% of your monthly earned income when combined with all other individual or group disability insurance. To determine this amount, see the enclosed insert.*

Elimination Period: *(Choose one.)* ☐ 90-day ☐ 180-day

Other Coverage: Do you now have or are you now applying for other disability insurance which provides benefits if you are unable to work because of disability? ..... ☐ Yes* ☐ No

* If you answered "Yes" please provide full details below. (Attach a sheet of paper if additional space is needed.)

Company	Plan	Monthly Benefit	Benefit Period	Elimination Period

3. Health Questions:

Yes No

☐ ☐ **1. Are you currently** performing all the duties of your job for the number of hours required (at least 30 hours per week)?

If no, please explain: _____.

2. 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

☐ ☐ **b.** High blood pressure

☐ ☐ **c.** Cancer or tumors

☐ ☐ **d.** Lung, respiratory or breathing disorders

☐ ☐ **e.** Diabetes

☐ ☐ **f.** Liver or kidney disorders

☐ ☐ **g.** Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones

☐ ☐ **h.** Mental or nervous illness or disorder, alcoholism or drug addiction

☐ ☐ **i.** Chronic pain or fatigue syndromes

☐ ☐ **j.** Neurological disorders such as Multiple Sclerosis or Parkinson's Disease

☐ ☐ **k.** Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome

☐ ☐ **l.** HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any other immune deficiency disorder (such as Lupus)?

☐ ☐ **3. Within the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis or treatment?

☐ ☐ **4. Within the last five years,** have you been attended by a doctor or licensed practitioner for anything other than a routine physical?

☐ ☐ **5. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?

☐ ☐ **6. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

If you answered "Yes" to any of questions 2-6, please provide full details below. (Attach a sheet of paper if additional space is needed.)

	Member Condition	Current Status	Last Visit	Physician Name	Physician Number
2					
3					
4					
5					
6					

3. Health Questions (continued):

Primary Care Physician Information:

Name:_____ Date last seen:_____/_____/_____

Address:_____ Telephone:_____–_____–_____

4. Please read, sign and date:

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 to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the MIB, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded) 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 MIB, Inc. to release any data it may have about me 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 coverage; and 4) 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. (In Montana only: I may request a record of any subsequent disclosures of protected 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, or a person authorized to act on my behalf, 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.

Important Notice: Virginia Residents: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Please keep this notice for your records.

X_____ **X**_____

Member Signature Date

Long Term Disability coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series: 83500. CA COA #1179, NAIC #68241.

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Complete this Payment Information Form and return it with your D.C. Long Term Disability Insurance Request for Coverage Form.

1. General Information

Name: _____
First Middle Initial Last

2. Account Information

☐ **Recurring Bank Account Withdrawal**
I request NCMIC Insurance Company electronically debit my bank account to pay my premium on each quarterly due date. I agree that NCMIC's rights in respect to each debit shall be the same as if it were a check signed by me. Should my bank account change, it is my responsibility to notify NCMIC. I verify that I am the accountholder.

Bank Name: _____
ABA/Routing #: _____
Account #: _____

or

☐ **Recurring Credit/Debit Card Payment with MasterCard® or VISA®**
I request NCMIC Insurance Company charge my credit/debit card to pay my premium on each quarterly due date. Should my credit/debit card change (including an updated expiration date), it is my responsibility to notify NCMIC. I verify that I am the accountholder.

Card #: _____
Expiration Date: _____

3. Authorization

By providing my account information and signing below, I hereby authorize recurring payments for my D.C. Long Term Disability Insurance Plan. This authorization will remain in effect until I notify NCMIC to cease recurring payments.

Signature of Applicant: X_____ Date: X _____

4. NBAC Membership

Not an NBAC member yet? To be eligible for the D.C. Long Term Disability Plan, you must be a member of NBAC. **If you'd like to become a member right now, simply sign and date below.** Non-refundable membership dues are just $15 per year. **The payment method for your NBAC membership will be the same as your disability plan payment.** (It will appear as two separate transactions on your statement.) By signing and dating, you give your permission for NCMIC Insurance Services to verify that you are a malpractice policyholder.

Signature: X _____ Date: X _____

5. Return this form with your Request for Coverage to NCMIC Insurance Services

By fax:
1-800-996-2642

Scan and email it to:
submissions@ncmic.com

By mail:
NCMIC Insurance Services
PO Box 9118
Des Moines, IA 50306