



“Diversified Insurance and Financial Services Since 1978”

PIC APPLICATION SUBMISSION CHECKLIST :: GEORGIA ::

- Complete pages 1 & 2 of the PIC Application
- Complete Consumer Understanding Form
- Complete Bank Draft Form (if to be placed on monthly bank draft)
- Attach copy of a voided check (if to be placed on monthly bank draft)

Please complete the below information:

DRAFT DATE: _____ **EFFECTIVE DATE** _____

AGENT'S NAME _____

Please submit all new business to:

BMC Agency, Inc.
1529 Sam Rittenburg Blvd.,
STE 200
Charleston, SC 29407

843.763.1602 Fax
hillaryh@bmcagency.com

FRAUD: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or 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 (in Georgia, Oregon and Nebraska "may be") a crime and subjects (in Georgia, Oregon and Nebraska "may subject") such person to criminal and civil penalties.

Check if replacing or changing existing coverage in this company. Policy Number _____

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.
			Primary Insured	/ /				- -
			Spouse	/ /				
			Child	/ /				COMPLETE SHADED
			Child	/ /				AREAS IF AVAILABLE
			Child	/ /				
Address			City	State	Zip	Home Telephone ()		
Secondary Addressee			City	State	Zip	Home Telephone ()		
Employer			Date Employed		Hours Worked/Wk			
Occupation		Monthly Income \$	Group Number		Employee/Payroll Number			
Payor or Owner if other than Primary Insured			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security No.		Relationship To Primary Insured		
Beneficiary						Age	Relationship	

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? ___Yes ___No. If "No", explain: _____

USED TOBACCO in the past 12 months? Primary Insured ___Yes ___No Spouse ___Yes ___No

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ___Yes ___No. If "Yes", complete replacement form where required.

INSURANCE PLANS								Monthly Premium	
DISABILITY Primary Insured Only		Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here			
<input type="checkbox"/> HPDI2002	Occ. Class	Injury \$							
<input type="checkbox"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2	Sickness \$			<input type="checkbox"/>				
RIDERS	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.		
Primary Ins.	\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Spouse	\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Children	\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$	
HOSPITAL		Base Policy	RIDERS	AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.
<input type="checkbox"/> 0/0	180 Primary Ins.	\$		\$	\$	\$	\$	\$	\$
<input type="checkbox"/> 0/0	365 Spouse	\$		\$	\$	\$	\$	\$	\$
<input type="checkbox"/> 0/3	365 Children	\$		\$	\$	\$	\$	\$	\$
RIDERS	Private Nurse	Surgical	Surgical+	Spec. Inj.	1st Hosp. Conf.				
Primary Ins.	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$	
Spouse	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$	
Children	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>		\$	\$	\$
CANCER		RIDERS	Surgical	Physician Att.	ICU	<input type="checkbox"/> Comp. Care	Disability Income \$500 (Primary Ins. Only)		
Base Policy	\$		\$	\$	\$	First Occurrence			
<input type="checkbox"/> Primary Ins.		Can. ICU	Chemo	Hospice	<input type="checkbox"/> \$500	<input type="checkbox"/> 6 Month Benefit			
<input type="checkbox"/> Family		\$	\$	\$	<input type="checkbox"/> \$1000	<input type="checkbox"/> 1 Yr Benefit			\$
LUMP SUM CANCER		<input type="checkbox"/> Individual	<input type="checkbox"/> 1 Parent	<input type="checkbox"/> 2 Parent	Max. issue in GA is \$30,000				
		<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000			
LIFE	<input type="checkbox"/> LPRT2002	Amount \$	<input type="checkbox"/> Accidental Death Rider		<input type="checkbox"/> Waiver of Premium				
	<input type="checkbox"/>	Units Family Rider	Units Children's Rider		<input type="checkbox"/> Other				

I. HAS ANY PROPOSED INSURED:

- A) In the last 10 years been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? Yes No.
 - B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? Yes No.
 - C) In the past 2 years had a driver's license suspended/revoked? Yes (License # _____ State _____) No.
- 2. IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? Yes No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

D1. FOR DISABILITY COVERAGE: List the amount of any other individual disability insurance currently applied for or in force for the primary insured \$ _____

C1. FOR CANCER COVERAGE: Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? Yes No

L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:

- A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? Yes No
- B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? Yes No
- C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor? Yes No

Details of "Yes" Answers in 1,D1,C1 or L1. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Insurance Information Practices: This notice describes the practices we, Professional Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

Agreement: I have read, or had read to me the completed application and agree that 1) all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8) no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

Home Office Corrections and/or Additions Only

I have have not received an Outline of Coverage. (For GA, MT, NV, OR, TX, WV)

X _____ Signed at _____ on ____/____/20____
 Signature of Primary Insured City, State Date
 (Parent if person to be insured is less than 15 years old)

X _____ X _____
 Signature of Owner (If other than Primary Insured) Spouse

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement is is not involved at this time.

X _____/____/20____ %
 Signature of Agent Date Agent's No. % Credit State ID No.

Professional Insurance Company

In California, PIC Life Insurance Company

Mailing Address: P.O. Box 80637, Lincoln, NE 68501-0637 1-800-289-1122

AUTHORIZATION TO HONOR CHECKS DRAWN BY PROFESSIONAL INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Professional Insurance Company, Lincoln Nebraska, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

A VOIDED CHECK MUST BE INCLUDED TO PROCESS YOUR REQUEST

Policies Covered by the Authorization

Policy Number	Premium Amt.	Draft Date	Name of Insured

If a Draft Date is not selected, the Company will use the drafting date occurring on or prior to the policy issue date.

I hereby authorize you to charge the account indicated below to pay the amount due on any insurance policy indicated for which I am obligated to pay premium.

Financial Institution _____

City, State, & Zip _____

Type of Account (circle one) Checking _____ Savings _____ Account Number _____

Printed Name _____ Payor _____
Sign Exactly as it appears on records of Financial Institution.

Instructions for Usage and Authorization

To: The Bank Named Above.

So that you may comply with your depositor's request, this Company agrees:

- 1 To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, or order, whether or not genuine, purporting to be executed by this company and received by you in the regular course of business for the purpose of payment (under this plan) including any costs or expenses reasonably incurred in connection therewith.
- 2 In the event that any such check, draft, or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently to indemnify you for any loss even though dishonor results in a forfeiture of insurance or other right.
- 3 To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of payment collection.
- 4 Authorized in a resolution adopted by the Board of Directors of:
PROFESSIONAL INSURANCE COMPANY

Consumer Understanding Section

Applicant's Name _____ Applicant's Signature _____ Agent's Name _____

1) The above referenced agent visited with me in reference to making an application for insurance with your company. The soliciting agent explained to me the provisions showing benefits, waiting periods, limitations, and exclusions. I have received an outline of coverage for the policy(s) for which I applied.

Applicant's Initials _____

2) I understand that PIC Hospital Indemnity policies are NOT Major Medical policies, and the policy(s) I am purchasing have limited outpatient coverage and doctor benefits. I know that this policy(s) will not cover everything, and that I will be responsible for some costs.

Applicant's Initials _____

3) I understand that I will not have insurance coverage with PIC until my application(s) has been approved and the Company has notified me that I have been accepted for coverage with a particular effective date. I also understand that in order to receive consideration under a "Guaranteed Issue" basis that I must be gainfully employed and working a minimum of 30 hours per week at the time of application.

Applicant's Initials _____

4) I understand that even though I may be accepted for coverage I may have exclusionary riders for particular pre-existing medical conditions, and that conditions for which I have sought or received treatment or manifest symptoms in the 12 months prior to my application date will not be covered until 12 months after my policy effective date if fully disclosed, and that I should not let any other coverage lapse until I have received and reviewed the PIC individual policy(s) in my name and found them to be suitable for my needs.

Applicant's Initials _____

5) I affirm and certify that I have answered all questions on the application(s) truthfully and completely, I have fully disclosed all health history on myself or any other family members listed on the application(s), and I understand that this agent has no authority to waive or modify any answer to any health question(s).

Applicant's Initials _____

BMC: 800-357-2342

Submit completed applications to:


BMC Agency, Inc., 1529 Sam Rittenberg Boulevard, Suite 200, Charleston, South Carolina 29407

* You can purchase the Outpatient Sickness benefit in addition to any of the four plan designs listed on the reverse side of this form; it pays \$50 for up to four different covered sicknesses in a calendar year per insured category (4 for employee, 4 for spouse and 4 for all children, not each child). If purchased in addition to the MAX PLAN design, this additional premium increases the Outpatient Sickness Benefit to \$100 for up to four covered sicknesses per insured category. This premium amount may be deducted from the posted MAX PLAN premium if you would like to eliminate the \$50 Outpatient Sickness benefit normally included in the MAX PLAN design. Please note that adding this benefit to the HSA Supplement plan design may alter your ability to make tax deductible contributions to a qualified Health Savings Account. Please consult with your personal tax advisor for details.

Subject to underwriting, a proposed insured may apply for an additional First Hospital Confinement Rider.

PIC "Guaranteed Issue" Supplemental Health Insurance

Premium Calculation Worksheet

Available to "full time" (30+ Hours / wk.) Workers in 

Please **CIRCLE** the **MONTHLY** premium amount(s) below that corresponds to your requested coverage.
Only **ONE** of these HI plans may be purchased, with or without the optional OP Sickness & FHC Rider(s).

I wish to apply for: Myself Myself & Spouse Myself & Children Family

	Emp	Emp/Sp	Emp/Ch	Family
HSA Supplement	\$29.91	\$58.07	\$45.57	\$73.73
Traditional/Copay	\$35.41	\$69.07	\$54.37	\$88.03
Cat Value	\$70.54	\$139.33	\$107.08	\$175.37
Max Plan	\$113.64	\$225.33	\$180.78	\$292.67
*Optional OP Sickness +/-				
* Optional FHC Rider				
Total Monthly Premium				

*Optional Outpatient Sickness Rider (This Rider is NOT Subject to additional Underwriting)

Employee	\$7.30
Employee Spouse	\$14.60
Employee/ Children	\$19.30
Family	\$26.60

Please **ADD** the \$50 Outpatient Sickness Benefit to my total plan premium. This may be added to ANY of the four plan designs.

Please **REMOVE** the \$50 Outpatient Sickness Benefit from my MAX PLAN premium.

First Hospital Confinement Rider (Rider is Subject to Underwriting)

Employee	\$12.50	Employee/ Children	\$19.50
Employee/ Spouse	\$25.00	Family	\$32.00

First Hospital Confinement Rider Upgrade

We believe the PIC Hospital Indemnity benefits to be the very best combination of solid benefits at a reasonable premiums in the Health Insurance industry today. Perhaps the very best, dollar for dollar, is the First Hospital Confinement Rider, included in each and every one of the popular plan packages described in our HI brochure. This benefit can provide as much as \$5,000 over a six day confinement by itself.

We have sought Home Office approval and been granted, under slightly tweaked guidelines to our basic Guaranteed Issue program, the opportunity to apply for a SECOND, that is an ADDITIONAL First Hospital Confinement Rider! Just to make absolutely certain that you understand, this means TWO FHC Riders, the one that comes with the "base" package, and an additional, second one on top, subject to underwriting approval! Here is how it works:

1) Select the rate for the Rider, based upon the plan selected and family composition. If the policy is being applied for as a 'family,' then the rider must be applied for as a family as well. Employee/ spouse base applications must apply for both employee and spouse. Rates are "4 tiered" and the rider must match the base plan.

2) Not being able to answer question 1A), the 'HIV/AIDS' question with a NO is an automatic decline for the RIDER ONLY. It does not affect the application for the base package of benefits AT ALL!

3) Once the applicant survives the 'HIV/AIDS" question, the second question, 1B , asks about conditions for which the applicant has consulted a physician, been treated or been hospitalized in the prior three years. If there are **THREE OR MORE** of these conditions, then the additional FHC Rider will not be issued, once again **not affecting the issue of the base plan at all.**

4) If there are less than three answers provided, that is conditions disclosed under question 1B, then the rider will be issued with an **exclusionary rider placed on the expressed/disclosed condition(s) only**. Even then, the policyholder can petition the company to consider removal of any riders in the future.

EXAMPLE: Applicant discloses under question 1B that they had a heart attack in 2009 and have been Diabetic since 2002. The FHC RIDER will be issued with permanent exclusions on the applicant for Heart Attack and Diabetes.

The cost of the FHC Rider is shown on the Consumer Understanding Form, and is repeated here:

<i>Employee</i>	<i>Employee/Spouse</i>	<i>Employee/Children</i>	<i>Full Family</i>
\$12.50/mo.	\$25.00/mo.	\$19.50/mo.	\$32.00/mo.

Include the corresponding premium to the base plan selected on line 7, just above the Total Monthly Premium line, and add it in to get the Total Monthly Premium.

I wish to apply for an additional First Hospital Confinement Benefit Rider, which I understand will be underwritten as described above. I am including the cost of this additional rider, \$_____, with my application.

Applicant Name: _____ Date: _____ Agent Name _____