

Unimerica Life Insurance Company

Statement of Insurability



1. **Policyholder's Name, Policy #, Status (if applicable).** This information is required in order to process the request for coverage. The Statement of Insurability form may already show this information. If this information is missing, please obtain the correct information from your Benefits Administrator and fill it in on the form prior to submitting your request for coverage. If this information is missing or incomplete it will delay your request for coverage.
2. **Product(s) Being Underwritten.** This section must be completed in order to process the request for coverage. This section refers to the type(s) and amount(s) of coverage you already have with LAPRA and are requesting at this time.
3. **Completing personal information on the form.** It is important that all the requested information be provided, including specific details to medical history, where asked. If this information is missing or incomplete it will delay your request for coverage.
4. **Signature(s) and date(s).** The signature and sign date must be completed on the bottom of the Statement of Insurability form where specified. We cannot process a request without this information. Forms with this information missing will be returned, which will delay your request for coverage.
5. **For your records.** Please make a copy of the completed form for your records. The Insurance Information Practices Notice should be reviewed and kept by you for your records.
6. **Submitting the form.** After completing, signing and dating the Statement of Insurability form, please follow the instructions given to you by LAPRA on how and where to submit it. If you have been instructed to mail the Statement of Insurability form directly to LAPRA, please use the "Return form to" address on the last page.

**Unimerica Life Insurance Company
Statement of Insurability**

Association Name **LOS ANGELES POLICE RELIEF ASSOCIATION, INC.**

Group # **302292** Member Employee Class: Active Retiree

Member Name _____ Member Social Security # _____

Member Home Address _____ City, State, Zip _____

Date of Birth _____ Date of Hire _____ Home Phone # _____ Work Phone # _____

Number of hours worked: _____ per week **(Applicable only to Active Members/Employees)**

Persons Proposed for Coverage

MEMBER INFORMATION	SEX (M/F)	HEIGHT (FT, IN)	WEIGHT (LBS)

PRODUCTS BEING UNDERWRITTEN –LIFE/AD&D INSURANCE

Please check ONLY ONE of the options below

I am not currently enrolled for Optional Life/AD&D through LAPRA and wish to apply for coverage at this time (not available to retirees)

I am applying to enroll in Plan 1 Plan 2 Plan 3 Plan 4 Plan 5 Plan 6

I am already enrolled for Optional Life/AD&D through LAPRA and wish to change my plan selection at this time

I am currently enrolled in Plan 1 Plan 2 Plan 3 Plan 4 Plan 5 Plan 6

I am applying to enroll in Plan 1 Plan 2 Plan 3 Plan 4 Plan 5 Plan 6

I am currently enrolled for Optional Life/AD&D through LAPRA and do not wish to change my plan selection at this time

PRODUCTS BEING UNDERWRITTEN – OFF DUTY LTD/AD&D INSURANCE (NOT AVAILABLE TO RETIREES)

Please check ONLY ONE of the options below:

I am not currently enrolled for Off-Duty LTD/AD&D through LAPRA and wish to apply for coverage at this time

I am not currently enrolled for Off-Duty LTD/AD&D through LAPRA and do not wish to apply for coverage at this time

I am already enrolled for Off-Duty LTD/AD&D through LAPRA

This Statement of Insurability is being submitted due to: Late Entrant Request for Increased Coverage

NAME, ADDRESS AND PHONE # OF PRIMARY CARE PHYSICIAN OF THE PERSON PROPOSED FOR COVERAGE:

DOCTOR NAME	
STREET ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	
DATE LAST SEEN	

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Insurance company or its reinsurer, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, or that of any member of my family whose name appears in the application to which this is attached to give Unimerica Life Insurance Company ("ULIC"), and its affiliates any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to ULIC at the address below. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right ULIC has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke this authorization, ULIC may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 30 months (24 months in KY and NM) from the date signed. I also understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject civil penalties, criminal penalties and/or the denial of insurance benefits. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage

Member Signature _____ Date _____

Return form to:

LAPRA 600 North Grand Avenue, Los Angeles, CA 90012-2212

Unimerica Life Insurance Company Insurance Information Practices Notice

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Statement of Insurability Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Statement of Insurability Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with Unimerica Life Insurance Company or its affiliates, and 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. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Unimerica Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Unimerica Life Insurance Company, or its reinsurers, may also release information in its files 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.