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

AICPA

AICPA Insurance Trust | Aon Securities LLC, Member FINRA/SIPC
1100 Virginia Drive, Suite 250, Fort Washington, PA 19034-3278

Request for Coverage Form—Business Overhead Expense Disability Plan

Complete this Form and return it in the enclosed postage-paid envelope. If approved by Prudential, you'll be billed after your insurance coverage is effective. If you are in the Plan and do not wish to make any changes at this time, you do not need to complete this Form. Any questions, please call Aon Insurance Services (Plan Agent) at 1-800-223-7473.

Member Information *(Please print in ink)*

First Name _____ MI _____ Last Name _____

Street _____ Apt. _____ City _____ State _____

ZIP Code _____ Social Security Number ___ — ___ — ____ Daytime Telephone Number ___ — ___ — ____

Evening Telephone Number ___ — ___ — ____ Email Address _____

Are you a member of the AICPA? *(AICPA membership is required)*

☐ No ☐ Yes, AICPA #_____

☐ **Yes,** I would like to receive the monthly AICPA Insurance Programs e-newsletter and other important information via email about training opportunities, products, offerings, and program-sponsored CPA events.

Legal Name of Firm for which you have Ownership Interest _____

Your Percentage share of covered expenses* _____ **%**

Form of ownership: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation

Are you now actively at work full-time at your Firm? *(at least 30 hours per week is required)* ☐ Yes ☐ No

Do you have other disability coverage that reimburses you for your share of the Firm's expenses? ☐ Yes ☐ No

If **"Yes"**, what is the maximum monthly benefit you are eligible to receive under that coverage? $_____per month

Maximum Monthly Benefit Amounts** *(Please check one)*

☐ **$12,000**	☐ **$8,000**	☐ **$5,000**	☐ **$3,500**	☐ **$2,000**
☐ **$10,000**	☐ **$7,000**	☐ **$4,500**	☐ **$3,000**	☐ **$1,500**
☐ **$9,000**	☐ **$6,000**	☐ **$4,000**	☐ **$2,500**	☐ **$1,000**

*See Definition of Covered Expenses furtheron.
**You must elect an amount not to exceed your share of the Firm's monthly expenses.

Monthly Gross Cost Per $1,000 of Benefit
Age as of each January 1

18-29	$ 2.80	**45-49**	$ 8.90
30-34	3.70	**50-54**	11.40
35-39	4.80	**55-59**	18.70
40-44	6.30	**60-69**	29.80

Contribution Payment Basis—If no election is made you will be billed on an annual basis.

I request the following payment basis *(please check one)***:**

☐ Annual ☐ Semi-Annual

Primary Care Physician Information—Failure to complete may delay your application process.

Name of your Primary Care Physician _____ ( ) Telephone No. of Primary Care Physician _____

Street Address of Primary Care Physician _____ City _____ State _____ Zip _____

☐ ***I do not have a Primary Care Physician at this time.***

Member Signature ✗_____ **Date** _____

By my signature above, I hereby request coverage under the Plan for the amount selected. I acknowledge that my application, is submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the application for coverage to the issuing company. I have read the Conditions Applicable to This Subscription and agree to those statements and conditions. I also hereby subscribe to the AICPA Insurance Trust in accordance with Member's Subscription and agree to the applicable conditions. Insurance is to become effective only upon acceptance by the issuing company. The Plan Agent, acting for the Trustee, will inform the person requesting insurance regarding the effective date of coverage.

Coverage under the AICPA Business Overhead Disability Expense Plan is issued by The Prudential Insurance Company of America, a New Jersey Company, 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. Contract provisions may vary by State. Contract Series 83500.

Please continue on reverse side...

The Prudential Insurance Company of America

Business Overhead Expense Disability Insurance
Health Statement Questionnaire

Medical Statements—Statements made by Member Requesting Coverage under the AICPA Business Overhead Expense Disability Plan provided by The Prudential Insurance Company of America (Prudential) pursuant to the AICPA Insurance Trust. ***Please print in black ink.***

1. Name of Member:

_____
Last *First* *Middle Initial*

2. Residence: Address Change? ☐ Yes ☐ No

_____
No. *Street*

_____
City *State* *Zip*

3. Date of Birth:

_____
Month *Day* *Year*

4. Birthplace:

_____
City *State*

5. Gender: ☐ Male ☐ Female

6. Height: _____ *ft.* _____ *in.*

Weight: _____ *lbs.*

7. Within the last 12 months have you used tobacco or nicotine in any form?:
☐ Yes ☐ No

8. Are you now actively at work Full-time:
☐ Yes ☐ No
(At least 30 hours per week is required)

Questions should be answered to the best of your knowledge and belief.

9. Have you within the last five years been treated for or had any symptoms of:

Yes*	No	
☐	☐	(a) Disease or disorder of the heart, blood, or circulatory system?
☐	☐	(b) High blood pressure, stroke, or abnormal pulse?
☐	☐	(c) Blocked arteries, including arteriosclerosis, atherosclerosis, aneurism, or deep vein blood clot?
☐	☐	(d) Respiratory disease or disorder of the lungs, including chronic obstructive pulmonary disorder (COPD), sleep apnea emphysema, or asthma?
☐	☐	(e) Disease or disorder of the stomach, gall bladder, or liver, including ulcers?
☐	☐	(f) Disorder of the kidney, bladder, or genitourinary system?
☐	☐	(g) Musculoskeletal disorders, including back, spinal, neck, or knee?
☐	☐	(h) Mental or nervous disorder?
☐	☐	(i) Diabetes? If "yes," indicate in question 12 whether Type 1 or 2, year of diagnosis, and current treatment.
☐	☐	(j) Cancer or tumors?
☐	☐	(k) Arthritis or joint disease or disorder? If arthritis, indicate type in question 13.
☐	☐	(l) Disease or disorder of the intestines, ulcerative colitis, or Crohn's disease?
☐	☐	(m)Muscular or neurological disease, such as Multiple Sclerosis or Parkinson's disease?
☐	☐	(n) Fibromyalgia, Chronic Fatigue Syndrome, or Chronic Pain Syndrome?
☐	☐	(o) Disease or disorder of the thyroid or endocrine system?

10. Have you within the last five years:

Yes*	No	
☐	☐	(a) Experienced a persistent cough, chronic fatigue, significant weight loss, night sweats, enlarged glands, or chronic diarrhea?
☐	☐	(b) Been advised to have a surgical operation?
☐	☐	(c) Been a patient in or been advised to enter a hospital or health care facility?
☐	☐	(d) Consulted or been attended by a doctor or other practitioner, other than for a routine physical, flu shot, or HIV testing?
☐	☐	(e) Been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?
☐	☐	(f) Been diagnosed or treated by a member of the medical profession for any immune deficiency disorder or disease of the lymphatic system or immune system, except HIV?
☐	☐	(g) Been treated or counseled for alcoholism or drug abuse?
☐	☐	(h) Regularly used barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor?

11. Are you currently taking any medicine prescribed or provided by a doctor? Please provide the name of the medication and reason for taking it in Question 13.
☐ Yes ☐ No

12. Have you, within the last five years, been diagnosed or treated for any physical disorders, impairments, or ill health, except HIV, not recorded in answer to Questions 9, 10, or 11?
☐ Yes ☐ No

If "Yes" is checked, please complete Question 13. When completing information below, please be sure to provide physician's name.

13. What are the complete details of all "Yes" answers to Questions 9, 10, 11, and 12?

Question number & letter	Specify illness, condition, and medication	Month/year illness or condition began	Time lost from normal activities	Month/year of full recovery (if applicable)	Print full name, address, and telephone number of physician(s)

☐ *Please check if additional medical information is attached.*

Primary Care Physician Information—Failure to complete this section may delay the processing of your application.

_____ ( )
Name of your Primary Care Physician Telephone No. of Primary Care Physician

_____
Street Address of Primary Care Physician City State Zip

☐ ***I do not have a Primary Care Physician at this time.***

Authorization for the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule.:

I authorize and instruct any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health care provider that has provided treatment or services to me within the past 5 years ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America ("Prudential") and to MIB, Inc. This excludes psychotherapy notes and information on the use of alcohol and drugs. I also authorize MIB, Inc. to release any data it may have about me for the proposed coverage with Prudential. By my signature below, I acknowledge that any agreements I have made to restrict the disclosure of health information do not apply to this Authorization and I instruct any of My Providers to release and disclose my entire medical record without restriction, including without limitation any restrictions on health care items or services for which a health care provider has been paid out of pocket in full.

Further, I declare that to the best of my knowledge and belief all of the above answers to the questions are complete and true. I agree that (1) the coverage and/or rates applied for is subject to the policy terms and shall become effective on the date or dates established by the policy, provided the evidence of insurability is satisfactory, (2) this form supersedes any prior form I may have completed with respect to the coverage and/or rates being applied for.

This information and any information on my application is to be disclosed under this authorization so that Prudential may, in accordance with the AICPA Insurance Trust and its administrator, Aon Insurance Services (Aon), do the following, with respect to the insurance coverage and/or rates I am applying for: underwrite or make rating determinations; evaluate and determine my eligibility for coverage; participate in audits by Prudential, AICPA, Aon or one of the third-party auditors, or conduct other legally permissible activities related to my application. I hereby authorize MIB, Inc. to exchange any medical records or knowledge of my health with The Prudential Insurance Company of America. By signing below, I acknowledge that I have received and read the Medical Information Notice, appearing in the brochure. This authorization is valid until the earliest of: (1) two years after the effective date of any coverage issued in connection with it; or (2) until it is withdrawn in writing; or (3) 24 months after the date it is signed. A photographic copy of this form will be as valid as the original. (If you wish, you may obtain a copy of this authorization).

I understand that I have a right to revoke the authorization in writing at anytime, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, PO Box 8796, Philadelphia, PA 19176. Attention: Senior Medical Underwriting Consultant. Any such revocation is subject to the rights of anyone who relied on this authorization before it was revoked. I understand that any information that is disclosed pursuant to this authorization may be redisclosed to other parties and will not be protected by the HIPAA Privacy Rule.

New York Residents: 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 a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to Long Term Disability Income Coverage.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

Member Signature: ✗_____ ***Date:*** _____

(All members must sign above regardless of state of residence)

By my signature above, I hereby request coverage under the Plan for the amount selected. I acknowledge that my application, including the portions containing health information, are submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the application for coverage to the issuing company. I have read the Conditions Applicable to This Subscription and agree to those statements and conditions. I also hereby subscribe to the AICPA Insurance Trust in accordance with Member's Subscription and agree to the applicable conditions. Insurance is to become effective only upon acceptance by the issuing company. The Plan Agent, acting for the Trustee, will inform the person requesting insurance regarding the effective date of coverage.

Member's Subscription—Effective on the date of application the member (of the AICPA or a State Society of CPAs or other qualifying organization) named herein, a subscriber to the Trust Agreement (hereinafter called the "Agreement") made in the City and State of New York as of January 1, 2012, as amended, by and between the American Institute of Certified Public Accountants, The Bank of New York Mellon, as successor Trustee, and the various Subscribers who from time to time subscribe to the Agreement, hereby amends a previous request for participation in the Insurance Plan of said Trust. Participation in the insurance is requested as indicated herein. **Conditions Applicable to this Subscription—**It is understood that the Agreement, among other things, provides that: (1) Subscribers shall make contributions to the Trust in such amounts as may be required for the purpose of providing and maintaining insurance in accordance with the plans of insurance under the Trust and for the purpose of administration; (2) Subscribers shall furnish to the Trustee any information required in connection with the administration of the Trust and the plans of insurance thereunder; and (3) the Trustee may modify the plans from time to time in any respect as may be directed by the Board of Directors of the Institute. It is further understood that: (1) if the Plan Agent, acting for the Trustee, shall determine that the Subscriber is eligible to participate as requested, the Plan Agent shall promptly confirm the effective date; (2) the insurance of an eligible individual shall, as to its effective date and in every other respect, be governed by the provisions of the contracts held and administered by the Trustee pursuant to the Plan (including the requirement that on the effective date the subscriber is actively at work on full-time at any location where his employment requires him to be); and (3) if the Subscriber is determined not to be eligible to participate as requested, this Form shall be considered null and void and the Trustee shall refund to the Subscriber any payment, but in the case of Subscribers currently participating in the Plan, continued participation on the basis existing prior to the date of this Form shall not be affected thereby.

Definition of Covered Expenses—"Covered Expenses" means your share of the actual monthly expenses that are normal and customary fixed business expenses in the conduct of your practice, such as rent or mortgage interest payments; real estate taxes; principal and interest payments on debt related to the purchase of the Firm; charges for electricity, telecommunications, heat and water; your employees salaries or wages; membership fees and dues to professional societies for you and your Firm; membership fees and dues to professional societies for your employees, if your Firm had made these payments at least six months prior to your disability; cost of continuing professional education required to maintain a professional license; cost of maintenance and repairs of equipment; cost of maintenance and repairs of computers and hardware; leased equipment and furniture payments; leased computer and hardware payments; leased software payments; software support contract payments; business loan interest on existing loans incurred prior to disability; subscription charges for professional journals or periodicals; software subscription charges for electronic professional journals or periodicals; other maintenance services; interest on office equipment loans; business insurance premiums, including insurance for errors and omissions liability and employee benefit plans; telephone answering service; depreciation of equipment; payroll taxes; other fixed overhead expenses that are normal and customary in the operation of your practice.

Special Notice—For your protection, certain state laws require the following to appear on this form. **For residents of all states except Alabama, District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, Utah, Vermont, Virginia and Washington: Warning:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Alabama Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **District of Columbia and Rhode Island Residents:** 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. **Kentucky Residents**: 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 commits a fraudulent insurance act, which is a crime. **Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Pennsylvania and Utah Residents:** 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 a crime and subjects such person to criminal and civil penalties. **Vermont Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law. **Virginia Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submit incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

An annual fee is paid by the Trust to the AICPA for administrative services and sponsorship.

If your request for Coverage or rates is denied and you disagree with this determination, you have the right to appeal it. Please contact the AICPA Customer Service Unit at 1-800-842-1718 weekdays from 8:00a.m. to 6:00p.m. Eastern time or write to: The Prudential Insurance Company of America, PO Box 8796, Philadelphia, PA 19176-8796.