Disability Income Plan
For Members of the State Bar of Wisconsin
Group number – 00165841

AnthemLife

Bultman Financial Services, Inc. 262-782-9949
13625 Bishops Drive, Suite 100 800-344-7040
Brookfield, WI 53005 Fax: 262-782-1454

To request disability insurance:
Complete this form in ink, indicate your choice of coverage and mail to plan administrator.

SECTION 1: MEMBER NAME AND ADDRESS

Last name	First name	M.I.	Social Security no.

Street address	City	State	ZIP code

Birthdate (MM/DD/YYYY)	Place of birth (city and state or province)	Gender
		☐ Male ☐ Female

Home phone no.	Work phone no.	Marital status
		☐ Single ☐ Married ☐ Divorced ☐ Widowed

SECTION 2: MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS

Are you now a member of the **State Bar of Wisconsin**? ☐ Yes ☐ No	Membership no.
Employer name	What is your occupation? _____ Are you actively engaged in your occupation on a full-time basis? ☐ Yes ☐ No

Gross Annual Earned Income: $_____ Your gross annual earned income must be at least $20,000 for you to be eligible for this coverage.

SECTION 3: INSURANCE REQUESTED

You may choose any monthly benefit option provided it does not exceed 70% of your gross earned income, when combined with other LTD coverages you may have.

Waiting period	Monthly benefit option ($300 minimum to $10,000 maximum per month, in units of $100)
☐ Plan A (30 day) ☐ Plan B (90 day) ☐ Plan C (180 day)	$_____

Do you now have or are you now applying for any other **long-term disability insurance** which provides benefits if you are unable to work because of a disability?
☐ Yes ☐ No If yes, list details below.

Company name	Plan	Monthly benefit	Benefit period
		$_____	

SECTION 4: SIGNATURE REQUIRED – Please initial any changes you make on this form

☐ By checking this box I certify that I have read the preceding answers and statements and declare that they are true and complete to the best of my knowledge and belief. I understand and agree that no agent has the authority to waive any questions or to determine insurability. I understand and agree that the policy will not take effect unless and until this application is approved and Anthem Life Insurance Company notifies me of my effective date.

Member signature	Date (MM/DD/YYYY)
X	

Anthem Life Insurance Company

Wisconsin Insurability Information Request

Anthem Life

Please keep a copy of this form/notice for your records

Anthem Life Insurance Company
PO Box 182361
Columbus, OH 43218-2361
Phone 800-551-7265
Fax 614-433-8880

Group no.
00165841

SECTION 1: GENERAL INFORMATION

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Social Security no.	Work phone no.	Home phone no.	Email address

Employee address	City	State	ZIP code	Height	Weight

Name of employer	Employer address

SECTION 2: MEDICAL AND ACTIVITIES QUESTIONNAIRE

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

1. Are you currently pregnant? ☐ Yes ☐ No
   If yes, expected due date_____(MM/DD/YYYY)
2. Have you smoked or used tobacco in the last five years? ☐ Yes ☐ No
   If yes, type _____
   Quit date (if applicable) _____(MM/DD/YYYY)
3. In the past 10 years, have you ever:
   a. Had high blood pressure or high cholesterol? ☐ Yes ☐ No
      If yes, last three readings_____
      _____
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? ☐ Yes ☐ No
   c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? ☐ Yes ☐ No
   d. Been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? ☐ Yes ☐ No
4. Have you ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or tested positive for antibodies to the Human Immune Deficiency virus? ☐ Yes ☐ No
5. In the past three years have you been prescribed medication? ☐ Yes ☐ No
6. In the past 10 years have you had an inpatient admission and/or outpatient surgery? ☐ Yes ☐ No
7. During the past 3 years, have you sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by the answers to the preceding six questions? ☐ Yes ☐ No
8. Have you ever been rated or declined for, or refused reinstatement or renewal of, life or health nsurance? ☐ Yes ☐ No
   If yes, date and reason:_____
   _____
9. In the past 3 years, have you been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? ☐ Yes ☐ No
   Please list: _____
   _____

IMPORTANT NOTICE: No person, including an employee or agent of Anthem Life has the authority to change or omit any of these medical questions.

Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Dates of treatment

Any remaining effects

Name of medication and dosage	Name and address of physician/hospital

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date. (continued)			
Question no	Name of individual	Name of illness or injury	Dates of treatment
Any remaining effects			
Name of medication and dosage		Name and address of physician/hospital	

SECTION 3: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, 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. If you question the accuracy of this 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, Massachusetts 02184-8734; and telephone number is 866-692-6901.

SECTION 4: AGREEMENT AND AUTHORIZATION

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. I am responsible for the timely notification to my employer of any changes that would make me ineligible for coverage.
4. I understand that Anthem Life Insurance Company reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.
5. ☐ By checking this box I certify that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage.

Applicant signature	Date (MM/DD/YYYY)
X	

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Anthem, PO Box 182361, Columbus, OH, 43218-2361. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

Wisconsin Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud.

Financial Statement
In connection with application to
Anthem Life Insurance Company for Disability Income Insurance
for Members of the State Bar of Wisconsin
Group number – 00165841

Bultman Financial Services, Inc. 262-782-9949
13625 Bishops Drive, Suite 100 800-344-7040
Brookfield, WI 53005 Fax: 262-782-1454

SECTION 1: APPLICANT INFORMATION

Last name	First name	M.I.

Are you self-employed? ☐ Yes ☐ No

If yes: ➜
- How long have you been self-employed? _____
- Are you working jointly with your spouse? ☐ Yes ☐ No
- If yes, indicate the number of other employees in the business (if any) and provide documentation of income.
- Number of other employees: _____

If no: ➜
- How long have you been employed at your current place of business? _____
- If less than one year, how long were you employed with your previous employer? _____
- Please provide employer names and address for the last five years.

Are you working out of your home? ☐ Yes ☐ No

If yes, is any work conducted outside the home? ☐ Yes ☐ No

Please explain and/or provide details:

How many hours per week are you working? _____

Are you a permanent U.S. resident? ☐ Yes ☐ No

Do you intend to live or travel outside of the U.S.? ☐ Yes ☐ No

If yes, for how long? _____

Have you lived or traveled outside the U.S. in the last two years? ☐ Yes ☐ No

If yes, please provide details.

Continued on reverse side

SECTION 2: CONFIDENTIAL FINANCIAL INFORMATION

Complete either Section A or Section B.

SECTION A: SELF-EMPLOYED

1. Sole Proprietor or Partner

Gross earned income (share of partnership income) in past 12 months or fiscal year ending: ____ $ _____
(Gross earnings before business expenses and taxes)

Your share of **total business expenses** for above period: $ _____

Net earned income, before personal income tax: $ _____

2. Professional Corporation

Annual salary currently drawn: $ _____

Annual cost of corporate-paid benefits: $ _____
(i.e., life or health insurance premiums, pension or profit sharing trust contributions paid on your behalf)

Your share of **dividends, bonuses and undistributed profits**: $ _____

Total annual earned income: $ _____

SECTION B: EMPLOYED

Annual Salary: $ _____

SECTION 3: IN–FORCE COVERAGE

Do you have any disability insurance in force? (Including group disability benefits) ☐ Yes ☐ No
If yes, complete details below.

Company name	Policy no.	Monthly benefit $	Elimination period	Benefit period

Have you recently applied for coverage with any other company? ☐ Yes ☐ No
If yes, list details:

Will this disability coverage applied for with us **replace** any of the above? ☐ Yes ☐ No
If yes, indicate which company, and date of termination below.

Company name	Termination date (MM/DD/YYYY)

SECTION 4: SIGNATURE REQUIRED – Please initial any changes you make on this form

☐ By checking this box I certify that I understand that any insurance issued will be in consideration of the answers and statements provided on this form and on any other forms or documents signed by me and made part of the certificate of insurance, if issued. I also understand insurance may be invalidated if Anthem Life Insurance Company finds that I have not answered the questions on this form truthfully and completely.

Member signature	Date (MM/DD/YYYY)
X	