Unimerica Insurance Company
Administrative Office: 9900 Bren Road East
Minnetonka, MN 55343

Group Life Insurance Application
Golf Course Superintendents Of America (GCSAA)
Policy Number: 1245

Office use only:
FACETS

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes. Answer *all* questions, then sign the Agreement and Authorization.

Member of Golf Course Superintendents Of America (GCSAA) Date of Membership: _____

_____

Section 1: Applicant Information

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1. Applicant Name: _____

2. Applicant SSN: ____--____--_____ 3. Email Address:_____

4. Billing Address: _____ City:_____ State: _____ Zip:_____

5. Home Address: _____ City:_____ State: _____ Zip:_____

6. Date of Birth: ___/___/____

If you are a resident of Maryland, do not answer 7 or 8

7. Place of Birth: _____ 8. Citizenship / Country: _____

9. Sex: θ Male θ Female 10. Daytime Phone #:_____--_____--_____

11. Your Current Occupation / Profession: _____ 12. How many hours a week do you work? _____

13. Please describe your duties: _____

14. Application is made for: ❒ New Coverage
❒ Increase Current Amount of Coverage: $_____
❒ Reinstatement Amount of Coverage: $_____

Section 2: Plan Selection

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1. Amount of Life Insurance Desired: $_____ $10,000 to $600,000 in $10,000 increments. If applying to increase coverage, indicate only the ADDITIONAL amount of Life Insurance desired.

2. Accidental Death and Dismemberment: ❒ Yes ❒ No
Amount of AD&D Principal Sum: $_____ $10,000 to $300,000, not to exceed the Amount of Life Insurance selected.

3. Life Insurance for Dependent Spouse: θ Yes θ No

Name of Spouse: _____ Date of Birth: ___/___/_____

If you are a resident of Maryland, do not answer this question. Place of Birth: _____

If you are a resident of Maryland, do not answer this question. Citizenship/Country: _____

Amount of Life Insurance desired for Spouse: $_____ $10,000 to $600,000 in $10,000 increments, not to exceed the Amount of Life Insurance selected by the Applicant

5. Life Insurance for Dependent Children: : θ Yes θ No

Name of Child _____ Date of Birth: ___/___/_____
Name of Child _____ Date of Birth: ___/___/_____
Name of Child _____ Date of Birth: ___/___/_____
Name of Child _____ Date of Birth: ___/___/_____

Amount of Life Insurance desired for Children: $_____

7. Full Name of Beneficiary: _____ Relationship: _____

8. Full Name of Contingent Beneficiary: _____ Relationship: _____
(The Applicant is the Beneficiary for Dependent coverage, if any.)

Section 3: Other Coverage

If You have other Life Insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Will Coverage be Replaced?	Who is insured by Other Coverage?
			θ Yes θ No	θ Applicant θ Spouse
			θ Yes θ No	θ Applicant θ Spouse
			θ Yes θ No	θ Applicant θ Spouse

Section 4: Financial Information

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1. Annual earned income as reported to the IRS on your personal and/or business federal tax return last calendar year: $_____
2. Net Worth: $_____

Section 5: Applicant/Spouse Statement of Health

Applicant

1. a) Height: ____ft. ____in.
   b) Weight: _____lbs.
   c) Weight change last year: _____ lbs.
   d) Reason for weight change: (Gain or Loss)

2. Name of Personal Physician (If none, please indicate):
   _____
   Physician Address: _____
   _____

   Date Last Seen: _____
   Reason: _____
   Results: _____

Spouse of Applicant

1. a) Height: ____ft. ____in.
   b) Weight: _____lbs.
   c) Weight change last year: _____ lbs.
   d) Reason for weight change: (Gain or Loss)

2. Name of Personal Physician (If none, please indicate):
   _____
   Physician Address: _____
   _____

   Date Last Seen: _____
   Reason: _____
   Results: _____

	Applicant	**Spouse of Applicant**
3. In the past 180 days, have you ever been: a. absent from work, or unable to perform any duty of your occupation because of sickness or injury?	θYes θNo	θYes θNo
b. been homebound or hospitalized because of sickness or injury?	θYes θNo	θYes θNo
(With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms or AIDS/ARC.)	If Yes to a) or b), for how many days? ____ Date(s):_____ Reason: _____	If Yes to a) or b), for how many days? ____ Date(s):_____ Reason: _____
	Applicant	**Spouse of Applicant**
4. Has anyone applying for coverage used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe, within the last 12 months?	θYes θNo	θYes θNo
5. In the past 10 years (5 years for residents of KS or MN), has anyone applying for coverage engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing?	θYes θNo	θYes θNo

Section 5: Applicant/Spouse Statement of Health (Continued)

	Applicant	Spouse of Applicant
6. In the past 10 years (5 years for residents of KS or MN), has anyone applying for coverage been medically diagnosed as having, or treated for, and with respect to residents of all states except MN or MO, include if anyone has experienced symptoms of: (indicate Yes/No and give details under Medical Details)		
a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system, blood or blood vessels? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC.)	θYes θNo	θYes θNo
b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung?	θYes θNo	θYes θNo
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder?	θYes θNo	θYes θNo
d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition?	θYes θNo	θYes θNo
e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease?	θYes θNo	θYes θNo
f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or disorder of the blood or immune system? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC.)	θYes θNo	θYes θNo
g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for Human Immunodeficiency Virus)?	θYes θNo	θYes θNo
h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease?	θYes θNo	θYes θNo
i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat?	θYes θNo	θYes θNo
j) chronic fatigue, Epstein Barr virus, fibromyalgia?	θYes θNo	θYes θNo
k) complications of pregnancy?	θYes θNo	θYes θNo
l) Are you pregnant? If "yes", due date:_____	θYes θNo	θYes θNo
7. In the past 10 years (5 years for residents of KS or MN), has anyone applying for coverage had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC. With respect to residents of WI, except for AIDS/HIV.)	θYes θ No	θYes θ No
8. In the past 10 years (5 years for residents of KS or MN), has anyone applying for coverage consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital?	θYes θ No	θYes θ No
9. Is anyone applying for coverage presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC.)	θYes θ No	θYes θ No
10. In the past 10 years(5 years for residents of KS or MN), has anyone applying for coverage:		
a. sought, been advised to seek, or received counseling or treatment for the use of alcohol?	θYes θ No	θYes θ No
b. used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received counseling or treatment for the use of prescribed or non-prescribed drugs; or ever been convicted for the possession of or use of prescribed or non-prescribed drugs? With respect to residents of all states except CT, include whether or not anyone was arrested for the possession of or use of prescribed or non-prescribed drugs With respect to residents of Maryland, do not respond relative to habit forming drugs other than those specifically listed.	θYes θ No	θYes θ No
c. been diagnosed or treated by a member of the medical profession (in VT a licensed medical physician) as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC.)	θYes θ No	θYes θ No

Section 5: Applicant/Spouse Statement of Health (Continued)

If you are a resident of CA, CO, CT, ME, NJ, VT or WI, do not answer the following question:

d. tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?

11. Within the past 10 years (5 years for residents of KS or MN), including the date of this application, has anyone applying for coverage had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application? (With respect to residents of ME, answer NO if you tested positive for HIV but have not developed symptoms of AIDS/ARC.) θYes θ No θYes θ No

Section 6: Medical Details (Please provide details if you answered YES to any item in the Applicant//Spouse Statement of Health Section:

Question #	Name of Person for whom you answered "YES"	Reason/Condition	Diagnosis/Treatment/ Results	Name, Address & Phone # of Physician and/or Hospital	Date of Onset	Date Last Seen	# of Days lost from work

Section 7: Fraud Notices

The following Notice applies to residents of AR, LA, NM, VA or WV. 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, criminal and civil penalties.

The following Notice applies to residents of ME. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The following Notice applies to residents of MA. 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.

The following Notice applies to residents of MN. Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

The following Notice applies to residents of NY: : 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 to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

The following Notice applies to residents of TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of coverage.

The following Notice applies to residents of VT:
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 may be a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

The following Notice applies to residents of all other states: 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 to civil penalties, criminal penalties, and/or the denial of insurance benefits.

Section 8: Agreement and Authorization

I hereby declare that all the statements made in this application 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 understand that, subject to the policy's deferred effective date provision, coverage will not become effective until Unimerica grants its underwriting approval. I understand that any condition which is excluded under the Policy will not be covered at any time.

I hereby authorize Unimerica to give information about me to any organization administering the coverage for which I am applying or as required by law.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, or that of any member of my family whose name appears in the application to which this is attached, to give Unimerica and its affiliates or authorized representative 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 Unimerica 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 Unimerica 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, Unimerica 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 understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months 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 and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that I and the producer if applicable also certifies that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

With respect to residents of VT, this authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The applicant IS NOT authorizing the company to forward the results of any new test required by the company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

Applicant Signature:_____ Dated: _____

Spouse Signature:_____ Dated: _____

The following additional notice applies only to residents of ME: This authorization excludes divulging whether tests for the presence of HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant or any other person to be covered has AIDS/ARC.

Retain a photocopy of this application for your records and return the original to Plan Administrator :

SRA Benefits
Attn: Erin Bellamy
5201 Johnson Drive
Suite 500
Mission, KS 66205