DISABILITY INCOME PLAN FOR MEMBERS OF THE STATE BAR OF WISCONSIN GROUP # - 00165841

Anthem Life

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.

MEMBER'S NAME AND ADDRESS

Name (Last, First, Middle Initial)	Social Security Number:
Address (Street Name/Number, City, State, Zip)	
Date of Birth	Place of Birth (City and State or Province) / Gender ☐ Male ☐ Female
Phone Number Home: Work:	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS

Are you now a member of the STATE BAR OF WISCONSIN? ☐ Yes ☐ No	Membership Number:
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.

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 ☐ Plan A (30 day) ☐ Plan B (90 day) ☐ Plan C (180 day)	Monthly Benefit Option $	($300 minimum to $10,000 maximum per month, in units of $100)
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? ☐ No ☐ Yes – list details at right	Company:	Monthly Benefit: $
	Plan:	Benefit Period:

PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM

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'S SIGNATURE	DATE
_____	_____

FINANCIAL STATEMENT

IN CONNECTION WITH APPLICATION TO ANTHEM LIFE INSURANCE COMPANY FOR DISABILITY INCOME INSURANCE FOR MEMBERS OF THE STATE BAR OF WISCONSIN – GROUP #00165841

Anthem Life

BULTMAN FINANCIAL SERVICES, INC. (262) 782-9949
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Brookfield, WI 53005 FAX (262) 782-1454

Applicant Name (Last, First, Middle Initial)
Are you self-employed? If yes, for how long?
If not self-employed, 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.
If self-employed, are you working jointly with your spouse? If yes, please indicate the number of other employees in the business (if any) and provide documentation of income.
Are you working out of your home? If yes, is any work conducted outside the home? Please explain and/or provide details.
How many hours per week are you working?
Are you a permanent U.S. resident?
Do you intend to live or travel outside of the U.S.? If yes, for how long?
Have you lived or traveled outside the U.S. in the last two years? If yes, please provide details.

(form continued on reverse side)

7129-05 (2/08)

BULTMAN FINANCIAL SERVICES, INC.
13625 Bishops Drive, Suite 100
Brookfield, WI 53005

(262) 782-9949
(800) 344-7040
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Anthem Life

CONFIDENTAL FINANCIAL INFORMATION

Complete either Section 1 or Section 2

Section 1. Self Employed	
A. 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):	$
Total Business Expenses for above period (your share):	$
Net Earned Income, before personal income tax:	$
B. 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 2. Employed	
Annual Salary	$

ANSWER THE FOLLOWING QUESTIONS REGARDING IN-FORCE COVERAGE

Do you have any disability insurance in force? (Include group disability benefits)

☐ No ☐ Yes – list details below

Company:	Policy Number	Monthly Benefit $	Elimination Period	Benefit Period

Have you recently applied for coverage with any other company?

☐ No ☐ Yes – list details

Will this disability coverage applied for with us *replace* any of the above? If yes, indicate which company, and date of termination.

☐ No ☐ Yes – list details

PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM

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'S SIGNATURE	DATE
_____	_____

7129-05 (2/08)

Evidence of Insurability Form

Group #

Anthem Life
Anthem Life Insurance Company
P.O. Box 182361
Columbus, OH 43218-2361
800-551-7265 614-433-8880 Fax

PART A - GENERAL INFORMATION

Please Print in ink or type

Last Name	First Name	Middle Initial	State of Birth	Date of Birth	Social Security Number
Name of Employer			Height	Weight	Work Phone #

PART B - DEPENDENT INFORMATION

Complete for all dependents (if any) to be covered under this program:

First Name	MI	Last Name (if different from Employee)	Height	Weight	Birthdate Mo . Day Yr.	State of Birth	Sex M or F	Relationship	Full-time Student Y or N	Eligible Income Tax Exemption Y or N
DO NOT COMPLETE								SPOUSE		

PART C - MEDICAL QUESTIONNAIRE

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical 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, clergy, 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 or any of your dependents currently pregnant? ☐YES ☐NO
   If yes, who? _____
   Expected due date: _____
2. Do you or any of your dependents smoke or use tobacco? ☐YES ☐NO
   If yes, who? _____
   Type? _____
3. In the past 10 years, has anyone 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. Has anyone 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)? ☐YES ☐NO
5. In the past three years has anyone been prescribed medication? ☐YES ☐NO
6. In the past 10 years has anyone had an inpatient admission and/or outpatient surgery? ☐YES ☐NO
7. During the past three years, has anyone sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by your answers to the preceding six questions? ☐YES ☐NO
8. Has anyone ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? ☐YES ☐NO
   If yes, name of person, date and reason:
   _____
   _____
9. In the past three years, has anyone been engaged in or does anyone contemplate being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? (Please list) ☐YES ☐NO
   _____

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

(To be detached and retained by applicant)
ANTHEM LIFE INSURANCE COMPANY
NOTICE TO PROPOSED INSURED
(Fair Credit Reporting Notice)

INVESTIGATIVE CONSUMER REPORTS

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our underwriting procedure, an investigative consumer report may be obtained which will provide information concerning residence, employment, finances, health, character, general reputation, personal characteristics, and mode of living. Such information for the investigative consumer report will be obtained through personal interviews with your friends, neighbors, and associates. This information may also be obtained by telephone interview with you or a member of your household. You may request to be personally interviewed. You may also request a copy of the investigative report. Upon written request to the Company's Underwriting Department, a complete and accurate disclosure of the nature and scope of the investigative consumer report will be provided. If you question the accuracy of the information in our files, you may request a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

If you answered yes to any questions 3 through 7, provide details below. If additional space is needed, please attach a separate page including your signature and date.

QUEST. 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

AGREEMENT AND AUTHORIZATION

I understand that, in order for Anthem Life Insurance Company to accept or decline this application, all of the information requested on the application must be completed. In the event that I have not correctly or fully completed this application, my signature shall authorize Anthem Life or its designee to obtain the necessary information for me and to complete that information on this application. I realize that Anthem Life reserves the right to accept or decline this application (or to accept only certain persons for coverage) and that no right whatsoever is created by this application.

For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowlege of me, or my health, or of my family for whom this insurance application is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health, or that of my family for whom insurance application is made, to the Medical Information Bureau, Inc.; or other life insurance companies in which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Anthem Life to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of two-and-one-half years. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

I certify that I have read, or have had read to me, the completed application and that all information is true and complete to the best of my knowledge. I understand that any misrepresentation or significant omission may void my coverage. I acknowledge that I have received the Fair Credit Reporting Notice. I also understand that any person who, with the 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 insurance fraud.

SIGNATURE OF APPLICANT **DATE**

SIGNATURE OF SPOUSE (If to be covered) **DATE**

IMPORTANT NOTICE

The underwriting process is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including statements in the application and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information in our file 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.