

(Use dark ink. This will be photographed.)

This application supplement is part of application(s) for insurance on the proposed insureds, as outlined in #4 and #5 below.

1. Name of Business Organization: _____ Date Organized: _____
 2. Form of Business (check one): Partnership C Corporation S Corporation Prof. Corporation
 Limited Liability Co. Indicate if Co. has a manager (give name) or is "member-managed": _____
 Other: _____

	Current Year	Last Year	Two Years Ago
3. Financial Data for Business Entity:	As of _____ (Date)	As of _____ (Date)	As of _____ (Date)
a. Current Assets:	\$ _____	\$ _____	\$ _____
b. Non-Current Assets:	_____	_____	_____
c. Current Liabilities:	_____	_____	_____
d. Non-Current Liabilities:	_____	_____	_____
e. Net Worth (Book Value):	_____	_____	_____
f. Gross Income/Sales:	_____	_____	_____
g. Net Profit (Loss) After Taxes:	_____	_____	_____
h. Officers' Compensation, including bonuses and dividends:	_____	_____	_____

4.	Names Of All Business Owners	Position Or Title	Current Annual Total Compensation From This Business	Percent Of Business Owned	Monthly Amount Of Disability Income Coverage In Force	Life Buy-Out Coverage In Force
			\$	%	\$	\$

5. Are all business owners of this business entity being insured? Yes No
 If no, explain: _____

6. Business Valuation Method Used (check one):
 Professional Service Organization – Owners' Compensation and Business Profit times two, plus Net Worth (including accounts receivable).
 Dental Practices – Owners' Compensation and Business Profit times one and one-half, plus Net Worth (including accounts receivable).
 CPA Firms – 150% of last three full year average of Gross Fees, plus Net Worth (excluding accounts receivable).
 All Others – Weighted Average – After Tax Income plus 15% of Owners' Compensation, times Earnings Factor (1-10), plus Net Worth.

(THIS FORM CONTINUES ON THE NEXT PAGE.)

Name of Business Organization: _____

For YES answers to Questions #7 through #8b, and for NO answers to Questions #9 through #11, please furnish details in #12 below.

- 7. Has the business organization experienced a net loss or a year to year decrease in net profit, before income taxes, in any of the last 5 years? Yes No
- 8. On any business owners proposed for this insurance:
 - a. Is there individual or group disability insurance or a salary continuation agreement in force, or applied for? Yes No
 - b. Is there other Disability Buy-Out coverage in force, contemplated or applied for? Yes No
- 9. Are all proposed insureds employed 100% of time in the business? Yes No
- 10. Is there a written disability Buy-Sell Agreement in effect?
 If yes, please attach a copy of the agreement. Yes No
 - a. If no, will a disability Buy-Sell Agreement be executed?
 If yes, indicate when in Remarks section.
 If no, disability Buy-Out insurance will not be issued. Yes No
- 11. Are all business owners aware of the need for a formal disability Buy-Sell Agreement that coincides with the provisions of the proposed coverage? Yes No

12. Other details: _____

Remarks: _____

I DECLARE that all answers to the above questions are true and complete to the best of my knowledge and belief. I agree that this application supplement shall be part of any contract of insurance based on such application. A photocopy of this application supplement is as valid as the original. In this application supplement, "I" refers to each proposed insured who signs below.

_____ SOLICITING AGENT'S SIGNATURE	_____ City, State Where Signed By Owner	_____ Date
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_____ Owner's Signature, if other than a Proposed Insured	_____ Date	_____ Signature of Proposed Insured	_____ Date
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_____ Signature of Proposed Insured	_____ Date	_____ Signature of Proposed Insured	_____ Date
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_____ Signature of Proposed Insured	_____ Date	_____ Signature of Proposed Insured	_____ Date
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_____ Signature of Proposed Insured	_____ Date	_____ Signature of Proposed Insured	_____ Date
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