

## **Mailing Instructions**

**Please mail your completed application  
and check to:**

National Insurance Markets, Inc.  
UTA – Life Policy  
915 Saxonburg Blvd, Suite 217  
Pittsburgh, PA 15223

**Make your check payable to:  
United Teacher Associates Insurance Company**

If you should have any questions, please contact us at:  
1-800-235-2013 or [info@nimbroker.com](mailto:info@nimbroker.com)

Thank you,

Your Customer Support Team at

[www.NIMBroker.com](http://www.NIMBroker.com)



## APPLICATION FOR LIFE INSURANCE

5508 Parkcrest Drive • P.O. Box 26580  
 Austin, Texas 78755-0580  
 (800) 880-8824  
 www.UTAic.com

Proposed Insured's Name:			Phone No.:	
Street Address:			Social Security Number:	
City:		State:	Zip:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Mo/Day/Yr)	Have you used tobacco in any form, in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Birth (State or Country)	Height:  Weight:
Owner (if other than Proposed Insured)		Relationship:	Address:	Phone No.:
				Social Security No.:
Beneficiary		Relationship:	Address:	Phone No.:
				Social Security No.:

If needed, attach additional contingent owner and/or beneficiary information on a separate paper.

POLICY APPLIED FOR:	
Plan of Insurance:	_____
Face Amount: \$ _____	Initial premium: \$ _____
Accidental Death Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select the date of month: (1st through 28th only) _____	
Mode: <input type="checkbox"/> PAC <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	
Is the coverage applied for intended to replace any existing life insurance or annuity with this or any other company: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", give name and address of company: _____	

**Proposed Insured must complete in all cases. Check yes or no for each question.**

*If the applicant answers "Yes" to any question in this section the insured is not eligible for coverage.*

- A. In the past 2 years have you been diagnosed as having a terminal illness or are you currently disabled or bedridden?  Yes  No
- B. In the past 90 days have you been hospitalized, confined to a long term care facility or a nursing facility, or used oxygen to assist in breathing?  Yes  No
- C. Have you ever been diagnosed, tested positive or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?  Yes  No
- D. Within the past 2 years have you been diagnosed with, undergone treatment for, or begun taking medication for or had any indication of internal cancer, melanoma, leukemia, brain tumor, Alzheimer's disease, liver disease, have you taken insulin for diabetes, or had an organ transplant?  Yes  No
- E. Within the past 2 years, have you been treated for or advised to seek treatment for alcoholism or drug use?  Yes  No
- F. Within the past 2 years have you been diagnosed as having, or been treated for heart disease or disorder, angina pectoris, heart attack, congestive heart failure, heart surgery, stroke, blood disorder (excluding Human Immunodeficiency Virus (HIV)), kidney disorder, kidney insufficiency (including dialysis), lung disorder, mental or nervous system disorder, Parkinson's disease or aneurysm?  Yes  No
- G. Name of Physician: (if no physician, write "None") Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone No. \_\_\_\_\_

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company. I personally completed the questions above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to United Teacher Associates or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this policy.

**Any person who knowingly and with intent to injure, or deceive any insurer, files a statement of claim or application, containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.**

Cash paid with application \$ \_\_\_\_\_.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
City State

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

**Instructions to agents - This statement must be completed with application.**

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be made payable to United Teacher Associates Insurance Company.
5. The full initial premium must be submitted with application.

**Agent's Statement**

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the proposed insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the insurance applied for is  is not  intended to replace any existing life insurance or annuity coverage. I personally did see  did not see  the applicant at the time of the application.

Agent Printed Name: \_\_\_\_\_ Agent Signature: \_\_\_\_\_

Agent Number: \_\_\_\_\_ Agent State ID Number: \_\_\_\_\_

**BANK CHECK PREMIUM PAYMENT PLAN**

**Authorization to Honor Drafts Drawn by: UNITED TEACHER ASSOCIATES INSURANCE COMPANY**

To: \_\_\_\_\_ City & State: \_\_\_\_\_

Bank Transit & Routing: \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of United Teacher Associates Insurance Company, Austin, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date: \_\_\_\_\_ Account Number: \_\_\_\_\_

Your Signature \_\_\_\_\_

Your Signature EXACTLY as it appears on Bank Records

## INVESTIGATIVE CONSUMER REPORT NOTICE

In compliance with federal and state laws, this is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared. The information for the report is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. The report includes information as to your character, general reputation, personal characteristics and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to us within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, United Teacher Associates Insurance Company, P.O. Box 26580, Austin, Texas 78755-0580

## MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

The information given in your application will be treated as confidential. United Teacher Associates Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit 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 in its file. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. United Teacher Associates Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted.

## CONDITIONAL RECEIPT

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNTIL EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO AGENT OR BROKER OF THE COMPANY IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

### A. LIFE INSURANCE

The sum of \$ \_\_\_\_\_ in connection with the application for Life Insurance with United Teacher Associates Insurance Company.

### B. TOTAL COLLECTED \$ \_\_\_\_\_

The conditions under which insurance, for which payment under A. above is intended, may become effective prior to policy delivery, are as follows:

1. The proposed insured(s) may be, on the Effective Date as hereafter defined, a risk acceptable to the Company under its rules, standards and practices for the exact policy and premium applied for, without modification.
2. The amount of payment taken with the application must be equal to the amount of the full first premium according to the mode of premium payment selected.
3. The policy is issued exactly as applied for within 60 days from the date of application. If each and every one of the above conditions shall have been fulfilled, then insurance as provided by the terms and conditions of the policy applied for will become effective, prior to policy delivery. The total amount of insurance (life insurance, accidental death benefits) which may become effective prior to policy delivery shall not exceed \$50,000. If one or more of the conditions is not met, the liability of the Company will be limited to the return of the sum received. "Effective Date" (coverage begins) as used herein means the later of: (a) the date the application is signed (b) the date of completion of all medical examinations, if required, or (c) the Requested Policy Date shown on the application.

\_\_\_\_\_  
Applicant's/Owner's Signature

\_\_\_\_\_  
Agent's Signature

Received from \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.