

HCC Life Insurance Company
13430 Northwest Freeway
Houston, Texas 77040



APPLICATION ENROLLMENT FORM

PART 1

ASU INTERNATIONAL INC. – ADMINISTRATOR

- Instructions:**
- Complete only in the presence of the Proposed Insured • Please PRINT in black and Initial ALL changes •
 - Answer all questions in their entirety • Any unanswered questions will delay the processing •
 - "N/A" or "None" are unsatisfactory answers and will not be accepted •

1. (a) Proposed Insured: _____
(referred to as You, Your) (Last) (First) (Middle)
- (b) Address of Proposed Insured: _____
(Street)

(City) (State) (Zip)
- (c) Sex: M F (d) Social Security # _____ / _____ / _____
- (e) Date of Birth: _____ (f) Place of Birth: _____
Month / Day / Year
- (g) Height: _____ (h) Weight: _____
- (i) Please indicate the name and address of Proposed Insured's primary physician, date last seen and reason for visit: _____

2. (a) Certificate Holder Name: _____
(if other than Proposed Insured)
- (b) Address of Certificate Holder: _____
(Street)

(City) (State) (Zip)

3. OCCUPATION OF PROPOSED INSURED

- (a) Occupation _____
- (b) Job Title: _____
- (c) Nature of Business: _____
- (d) Describe, in order of importance, all major duties of Your Occupation.

<u>Description of Duties</u>	<u>% of time devoted to this activity</u>
_____	_____
_____	_____
_____	_____

3. OCCUPATION OF PROPOSED INSURED (Continued):

(e) Are You now at work at least 30 hours a week in this Occupation? Yes No

If No, explain: _____

(f) Number of years in this Occupation: _____

(g) Former Occupation, if changed within two years: _____

(h) i) Do You have any other part or full time jobs? Yes No

If Yes, describe: _____

ii) If an owner, percentage owned _____% Years owned _____

iii) Type of Business entity: Sole Proprietor Partnership S Corp C Corp

Other (Describe) _____

4. DISABILITY INSURANCE COVERAGE OF THE PROPOSED INSURED

a) List all disability insurance now in force or applied for with all companies, including HCC Life Insurance Company.

If NONE, check here: _____

Code Type of Insurance: IND = Individual G = Group A = Association
 Identify: I = In force P = Pending

Insurance Company	<u>Type:</u> I or P	<u>Type:</u> Disability Income/ Key Person/ Overhead/ Buyout	<u>Type:</u> IND, G or A	Amount of Lump Sum or Monthly Indemnity	Benefit Period Injury/Sickness	Date of Eligibility	Check if
							Employer Pays Premium

b) Will You become eligible for group disability income insurance in the next six months? Yes No

c) What part of the premium for this Policy will Your employer pay? \$ _____ or _____% None
 How much of this premium will be included in Your taxable income? \$ _____ or _____% None

d) Do You pay Social Security taxes (FICA or Schedule SE)? Yes No

If no, explain _____

5. PERSONAL FINANCIAL INFORMATION OF THE PROPOSED INSURED

a) *Earned income* means the compensation which You receive for work or personal services, after business expenses, but before any other deductions, as reported for federal income tax purposes on IRS Form 1040.

Earned income does not include *passive or unearned income* from dividends, interest, rentals or royalties. It is not Adjusted Gross Income.

Do not enter any amounts that are not reported to the IRS.

Current Year Estimated
Jan 1 - Dec 31 20__

b) **EARNED INCOME**

- 1. Salary or Wages from Form W2 _____
- 2. Sole Proprietor Net Profit from 1040 Schedule C _____
- 3. Share of Partnership or S Corp Non-passive Income from 1040 Schedule E _____
- 4. Pension Plan Contributions or Elective Deferred Compensation which would cease if the Proposed Insured were disabled _____
- 5. Bonus, Commission or Other Earned Income from this Occupation (explain in Remarks below) _____
- 6. Other Earned Income from any other full or part-time work (explain in Remarks below) _____

TOTAL EARNED INCOME

(Add above amounts)

c) **UNEARNED INCOME** including passive income, if it exceeds \$20,000 in either of the last two years.

d) **NET WORTH** - Is Your net worth greater than \$4,000,000? Yes No

If yes, describe Your net worth in detail. Show current value less indebtedness.

Cash, savings, stocks and bonds \$ _____ Personal property \$ _____

Business \$ _____ Personal residence \$ _____

Other real estate \$ _____ Other \$ _____

e) *Explain* any fluctuations in income that exceed 20% of the prior year or any special circumstances that may affect Your earned income in the Remarks section.

f) Remarks

6. REPLACEMENT

Will the new HCC Life Insurance Company Policy replace any disability income insurance? Yes No
 If yes, list all other coverage(s) below.

When issuing any insurance as a result of this Application Enrollment Form, HCC Life Insurance Company will rely on the fact that the Proposed Insured can and will terminate the coverage listed below by the next premium due date following delivery of the HCC Life Insurance Company Policy. HCC Life Insurance Company may contact any listed insurer after the date shown to confirm that the coverage has been permanently terminated.

Failure to terminate the coverage shall result in cancellation of the coverage applied for hereunder from its inception.

Insurance Company	Type:		Certificate/ Policy Number	Amount to be Replaced & Mode	Next Premium Due Date and Mode
	Personal Disability Income/ Key Person / Overhead / Buyout	Group or Association Name			

7. Has the Certificate Holder, Proposed Insured or anyone else, ever made any claim(s) against any insurer or self-insured plan for disability to the Proposed Insured resulting from injury or sickness? Yes No

If Yes, provide the name(s), date(s) of all claim(s) and the amount(s) of all benefits received from any insurer or self-insured plan:

8. Has any Life, Health or Accident insurer or self-insured plan ever canceled, declined to accept any application or renewal, or only accepted, renewed or quoted on special rates, terms or conditions, any insurance on the Proposed Insured? Yes No

If Yes, provide the reason(s) for declination, special rates, terms and/or conditions:

HCC Life Insurance Company - 13403 Northwest Freeway - Houston, Texas 77040

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1. Proposed Insured: (referred to as You, Your) (Last) (First) (Middle)
2. Date of Birth: (Month / Day / Year) Sex: Male [] Female [] Occupation: _____

HEALTH HISTORY

3. Hospitalizations: Have You ever been a patient, either inpatient or outpatient, in a hospital, clinic or other medical facility? Yes [] No []
If Yes, please provide full details. Include all years, name of facilities, duration of injury, sickness surgery and treatment.

4. Medications: a. Do You presently take any prescribed medicines? Yes [] No []
If Yes, provide prescribing physician's name(s) and list names & dosage of each medicine, how often You take it and reason(s) for taking each.

b. During the past five (5) years, have You taken any prescribed medicines (including any cortisone shots) or any pain reducing or anti-inflammatory medications or treatments? Yes [] No []
If Yes, provide prescribing physician's name(s) and list names & dosage of each medicine, frequency and reason(s) for taking each.

c. Do You presently take any non-prescription (over-the-counter) medicine(s) or tonics? Yes [] No []
(For example, laxatives, diet pills, dietary supplements, vitamins, antacids, cold medicines, etc.)
If Yes, list name(s), dosage, how often You take it and reason(s) for taking each.

d. Within the past two (2) years have You had any injury(ies) or sickness(es) which has caused discomfort or pain for which medical advice(s) and/or treatment(s) have not yet been sought? Yes [] No []

5. Have You ever suffered from or ever been medically treated by a physician, chiropractor, psychiatrist, psychologist or drug, alcohol or mental health counselor or any other health practitioner for:
a. glaucoma, cataracts, failing vision not corrected with glasses or contact lenses, persistent hoarseness, loss of hearing or any other disease, injury, syndrome or disorder of the eyes, ears, nose, mouth or throat? Yes [] No []

PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

HEALTH HISTORY

- b. neuritis, sciatica, arthritis, gout, or any other disease, syndrome or disorder of the muscles, nerves, cartilage or bones; including but not limited to the spine, back, knees, shoulders, or elbows or any other joints? Yes No
 - c. chest pain, palpitation, arrhythmia, heart attack, angina, high blood pressure, heart murmur or any other cardiovascular disease, syndrome or disorder of the heart? Yes No
 - d. colitis, ulcer, hernia, diverticulitis, hepatitis, or any other disease, syndrome of the stomach, liver, intestines, gall bladder, rectum or pancreas? Yes No
 - e. shortness of breath, persistent cough, asthma, tuberculosis or any other respiratory disease, syndrome or disorder? Yes No
 - f. any sexually transmitted disease, sugar, albumin protein, blood or pus in the urine or an infection or disorder of the kidneys, bladder, urinary tract, prostate or reproductive organs? Yes No
 - g. dizziness, fainting, convulsions, seizures, severe or persistent headaches, depression, stress, chronic fatigue, mononucleosis, paralysis, stroke or any emotional, nervous, behavioral or mental problem, disease, syndrome, disorder or illness? Yes No
 - h. unexplained weight gain or loss of more than 20 pounds, diabetes or any other disease, syndrome, or disorder of the thyroid, pituitary, adrenal or parathyroid gland? Yes No
 - i. allergies or any other disease, syndrome or disorder of the skin or lymph glands? Yes No
 - j. hysterectomy or prostatectomy or any other disease, syndrome or disorder of the breasts, uterus, tubes, ovaries, vagina, penis, prostate or testicles? Yes No
 - k. anemia, hemophilia, clotting disorder, leukemia, or any other disease, syndrome or disorder of the blood or blood vessels? Yes No
 - l. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? Yes No
 - m. cysts, tumor or cancer, either benign or malignant? Yes No
6. **IN THE PAST 3 YEARS HAVE YOU HAD ANY OTHER INJURY, ILLNESS, SICKNESS, DISEASE OR SYNDROME, CONGENITAL DEFORMITY, ABNORMALITY OR DISORDER NOT LISTED OR MENTIONED ABOVE?** .Yes No
7. Have You:
- a. used marijuana, cocaine, heroin, morphine, barbiturates, amphetamines, hallucinogens or any other narcotic or drug? Yes No
 - b. sought or received or been recommended to receive advice for or treatment of, or been arrested for the possession of or the use or abuse of alcohol or drugs? .Yes No
8. Have any of Your BLOOD RELATIVES of ever suffered from a stroke or cancer, heart, or kidney, or diabetes, or high blood pressure, or mental or emotional disease, syndrome or disorder? Yes No
9. Have You:
- a. within the past five (5) years, obtained license for or participated in hunting, piloting, parachuting, sky diving, snow skiing, water skiing, scuba diving, motor racing, or any other similar type sport(s) or activity(ies)? Yes No
If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

 - b. Are You currently or do You intend to obtain license for or participate in any sport(s) or similar type of activity(ies) as shown in 9.a. above? Yes No
If Yes, provide full details of sport(s) and/or activity(ies) and frequency of each.

10. Has the Proposed Insured, in the last 12 months, seen any physician(s) and/or received any treatment not indicated in response to any of the prior questions? Yes No
If Yes, please list name(s) and address(es) of all physicians with dates You were seen and reason(s) for each visit:

PROVIDE ON PAGE 7 FULL, WRITTEN DETAILS OF ALL QUESTIONS ANSWERED "YES"

Continue Full, Written Details of All Questions Answered "Yes"

A signed Notice and Authorization to obtain Information must be attached for this to be a complete part of this Application Enrollment Form

ASU INTERNATIONAL INC. - ADMINISTRATOR

FRAUD NOTICES

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT, WITH REGARD ON THE WAY TO A SETTLEMENT, OR AWARD PAYABLE FROM INSURANCE PROCEEDS, SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "**WARNING:** IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM, FOR PAYMENT OF A LOSS OR BENEFIT, IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

NOTICE TO KENTUCKY APPLICANTS: "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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO LOUISIANA APPLICANTS: "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."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR A 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 CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000, AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATIONS."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION, OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "**WARNING:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

ASU INTERNATIONAL INC. - ADMINISTRATOR

FRAUD NOTICES
(continued)

NOTICE TO TENNESEE AND VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE INSURER. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

The Certificate Holder and Proposed Insured declare that all responses made to each and every question in this Application Enrollment Form are true and complete. The Certificate Holder and Proposed Insured understand that: (a) any false statements or material misrepresentations shall result in the loss of coverage(s) under any policy which may be in force and/or any coverage(s) which are being offered; (b) no representation made to or information possessed by any agent shall be binding on the Company unless disclosed in this Application Enrollment Form.

(Signature of Proposed Insured) (Print Name)

Date: _____ Signed at: _____
(Month / Day / Year) (City and State)

(Signature of Certificate Holder, if other than Proposed Insured) (Print Name)

Date: _____ Signed at: _____
(Month / Day / Year) (City and State)

Agent/Broker Signature: _____

ALL FORMS SHOULD BE RETURNED DIRECTLY TO:

ASU INTERNATIONAL INC.
500 UNICORN PARK DRIVE
WOBURN, MA 01801
PHONE: 781-994-6000 - FAX: 781-994-6001

HCC Life Insurance Company - 13403 Northwest Freeway - Houston, Texas 77040
(referred to as "We," "Our", "Company")

ASU INTERNATIONAL INC. - ADMINISTRATOR

NOTICE TO PROPOSED INSURED

As a part of Our normal procedure for processing Your Application Enrollment Form, We may get an investigative consumer report. Information may be secured through personal interviews with Your friends, neighbors and others with whom You are acquainted. This report typically contains information as to Your character, general reputation, personal characteristics, and mode of living. Within a reasonable period thereafter, You have the right to request in writing a complete and accurate disclosure of additional information concerning the nature and scope of this report, including the name and address of the consumer reporting agency to whom the request was made. Upon the furnishing to You of the name and address of the consumer reporting agency to whom the request was made, We will also inform You that You may inspect and receive a copy of such report by contacting such agency. Please address Your request to Our "Underwriting Department," HCC Life Insurance Company, c/o ASU International Inc., 500 Unicorn Park Drive, Woburn, MA 01801.

AUTHORIZATION

You hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of You or Your health to give to HCC Life Insurance Company any such information to the extent permitted by law. You also hereby authorize HCC Life Insurance Company to procure or cause to be prepared an investigative consumer report. You expressly waive under this Application Enrollment Form all provisions of the law prohibiting disclosure of information obtained as a result of Your authorization, and You expressly authorize such disclosures and authorize testimony as to such information. You acknowledge receipt of the "NOTICE TO PROPOSED INSURED". A photographic copy of this acknowledgment shall be as valid as the original.

Date

Signature of Proposed Insured (Referred to as You, Your)

Date

Witness