Request for Coverage Form

To request coverage, mail this completed Form to:
Application Examiner, Capitol Tower,
206 E. 9th Street, Suite 1501, Austin, Texas 78701.
Please do not include payment now—You will be billed when notified of your coverage effective date.
Questions? Please call 1-800-460-7248.

Please print all answers using black ink.

Group Policy No. 47080

1 Member Information

First Name ____ MI ____ Last Name ____

Street ____ Apt. ____

City ____ State ____ ZIP code ____ ____

Date of Birth (mm/dd/yyyy) ____

Social Security Number ____ – ____ – ____

Daytime Telephone Number ____ – ____ – ____

Sex ☐ Male ☐ Female

Height ____ ft. ____ in.

Weight ____

Evening Telephone Number ____ – ____ – ____

❑ ***Yes,*** *I would like to receive important information via email about training opportunities, products, offerings, and program-sponsored SBOTIT events.*

Email ____

I am employed by a Member's law practice: ☐

State Bar of Texas Member: ☐

Bar Card Number ____

Date of Full-time employment (mm/dd/yyyy) ____

Are You: ☐ A New Applicant ☐ Increasing Present Coverage Current Coverage Amount $________________

If you are increasing coverage in force, your present amount plus additional amount equals the amount you indicate. (If you do not qualify for the increased amount, your present amount remains in force.)

2 Spouse/ Domestic Partner and Dependent Child Information

Complete if you are requesting coverage for your spouse/ domestic partner or dependent child.

Spouse/Domestic Partner Information

First Name ____ MI ____ Last Name ____

Date of Birth (mm/dd/yyyy) ____

Social Security Number ____

Daytime Telephone Number ____

Sex ☐ Male ☐ Female

Height ____ ft. ____ in.

Weight ____

Evening Telephone Number ____ – ____ – ____

Dependent Child Information

Child's Name	Date of Birth

3 Health Questions

Please answer these questions by checking "Yes" or "No."

Member Yes	Member No	Spouse/Domestic Partner Yes	Spouse/Domestic Partner No	Question
☐	☐	☐	☐	**1. Are you currently** performing all the duties of your job for the number of hours required? If no, please explain:____________________
				2. Within the last five years, have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:
☐	☐	☐	☐	**a.** Disease or disorder of the heart, blood or circulatory system
☐	☐	☐	☐	**b.** High blood pressure
☐	☐	☐	☐	**c.** Cancer or tumors
☐	☐	☐	☐	**d.** Lung, respiratory or breathing disorders
☐	☐	☐	☐	**e.** Diabetes
☐	☐	☐	☐	**f.** Liver or kidney disorders
☐	☐	☐	☐	**g.** Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones
☐	☐	☐	☐	**h.** Mental or nervous illness or disorder, alcoholism or drug addiction
☐	☐	☐	☐	**i.** Chronic pain or fatigue syndromes
☐	☐	☐	☐	**j.** Neurological disorders such as Multiple Sclerosis or Parkinson's Disease
☐	☐	☐	☐	**k.** Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome
☐	☐	☐	☐	**Within the last five years**, have you been diagnosed with or treated by a physician for, Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS) or any other immune deficiency disorder (such as Lupus)?
☐	☐	☐	☐	**3. Within the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
☐	☐	☐	☐	**4. Within the last five years,** have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
☐	☐	☐	☐	**5. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?
☐	☐	☐	☐	**6. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

If you answered "Yes" to any of questions 2-6, please provide full details below.
(If more space is needed, please attach an additional sheet.)

Member	Spouse/ Domestic Partner	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
☐	☐					
☐	☐					
☐	☐					

Primary Care Physician Information for Member or Employee

Name	Date last seen	Telephone

Address

Primary Care Physician Information for Spouse/Domestic Partner

Name	Date last seen	Telephone

Address

4 Coverage Amounts

Choose the type of coverage and amounts for which you are applying.

☐ **Member Term Life Insurance:**

Member *(please check one)*:

☐ $100,000 ☐ $600,000
☐ $200,000 ☐ $700,000
☐ $300,000 ☐ $800,000
☐ $400,000 ☐ $900,000
☐ $500,000 ☐ $1,000,000*

Spouse/Domestic Partner*
(please check one):

☐ $10,000
☐ $50,000
☐ $100,000
☐ $150,000
☐ $250,000
☐ Other *(in $10,000 increments)* $________________

Children*
(please check one):

☐ $2,000
☐ $4,000
☐ $6,000
☐ $8,000
☐ $10,000

*No Member can be covered for more than $1,000,000 of SBOTIT Life Insurance.
**Dependent coverage cannot exceed 50% of the Member amount. No Spouse/Domestic Partner can be covered for more than $250,000 of SBOTIT Life Insurance.

☐ **Employee Term Life Insurance:**

Member *(please check one)*:

☐ $10,000 ☐ $60,000
☐ $20,000 ☐ $70,000
☐ $30,000 ☐ $80,000
☐ $40,000 ☐ $90,000
☐ $50,000 ☐ $100,000

Spouse/Domestic Partner†
(please check one):

☐ $10,000
☐ $20,000
☐ $30,000
☐ $40,000
☐ $50,000

Children†
(please check one):

☐ $2,000
☐ $4,000
☐ $6,000
☐ $8,000
☐ $10,000

†Dependent coverage cannot exceed 50% of the Employee amount.

☐ **Personal Accident Insurance:**

Member: $______________________ (in increments of $25,000, up to a maximum of $500,000)

Spouse/Domestic Partner: $______________________ (in increments of $25,000, up to a maximum of $500,000. *Spouse's/Domestic Partner's amount may not exceed member's amount.*)

Children: $______________________ (in increments of $5,000, up to a maximum of $15,000 each)

☐ **Long Term Disability Insurance—**This election requires you to provide completed Evidence of Insurability form.

Please complete the following to determine the total amount of benefits you are eligible to apply for:

Total Monthly Gross Income: **(a) $** ______________
Calculate 66 2/3% of Monthly Income (to nearest $100): **(a) x.66 2/3=(b) $** ______________
Total SBOTIT LTD Monthly Benefit cannot exceed this amount: **=(c) $** ______________

You are eligible to apply for up to the amount of coverage shown in (c). The amount of coverage requested from SBOTIT cannot exceed $10,000 per month (the minimum amount is $300).

Your total monthly benefit may be allocated among the waiting periods in minimum units of $100.

Plan	Waiting Period	Monthly Benefit
❑ A	30 Days*	$ ____________
❑ B	90 Days	$ ____________
❑ C	180 Days	$ ____________
❑ D	365 Days	$ ____________

Maximum Benefit Period:
❑ Plan I ❑ Plan II ❑ Plan III

Include Cost of Living Adjustment (COLA) Provision? ❑ Yes ❑ No (available only under Plan I and II)

**Maximum monthly benefit is $10,000, but only $2,000 may be under Plan A.*

☐ **Office Overhead Expense Insurance:**

Average monthly overhead expense for the last six months: $__________________

Monthly Benefit Desired: $________________

(Member may apply for increments of $100 up to $5,000. Payments will be made on actual expenses only.)

5 Beneficiary Information

Full Name of Beneficiary | Relationship | Share %

Address

(If more space is needed, please attach a separate sheet.)

Total (Must equal 100%) **100%**

6 Contribution Payment Basis

I request the following payment basis *(please check one)*:

☐ Bill me Monthly ☐ Bill me Quarterly ☐ Monthly Electronic Fund Transfer (EFT)*

**If electing EFT, you must complete the Electronic Fund Transfer Authorization section below.*

7 Electronic Fund Transfer Authorization

If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your savings account, enclose a copy of a voided deposit slip. By my signature below I authorize the State Bar of Texas Insurance Trust in accordance with the Agreement (included on page 5 of this Form) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

Type of Account: ☐ Checking ☐ Savings

Account Owner's Name | Bank Name

Bank's Transit Routing Number | Your Account Number

X

Signature of Account Owner

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization to release the entire medical record for me, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my knowledge and belief. I understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I also understand that coverage will not take effect if the facts have changed. I have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

X

Member Signature | Date (mm/dd/yyyy)

X

Spouse/Domestic Partner Signature | Date (mm/dd/yyyy)

Important Notice: For residents of all states except Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington: Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **New York Residents:** 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 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident and disability income coverage. **Pennsylvania and Utah Residents:** 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 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. **Vermont Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law. **Virginia Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. **Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Accelerated Death Benefits—Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Beneficiary Designation—If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to the first of the following: your (a) surviving spouse/domestic partner or registered domestic partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

Electronic Fund Transfer Authorization: State Bar of Texas Insurance Trust Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the first of each month that the payment is due. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes. If you are a current participant and would like to change your payment basis, please call 1-800-460-7248.

Please keep this notice for your records.