



Lincoln Mutual Life and Casualty

4510 13th Ave S • PO Box 1918 • Fargo, ND 58107-1918
Toll-free 1-800-233-6050 • Fax 701-282-1840 • www.lml.com • lmlgroup@lml.com

Lincoln Mutual
Life and Casualty Insurance Company
APPLICATION FOR GROUP DISABILITY INSURANCE
Business Overhead Expense Coverage

1. Name of Applicant: _____

2. Address: _____
(Street)

(City)

(State)

(Zip)

3. Number of Years in Business: _____

4. Policy Effective Date: _____

Above named applicant applies to Lincoln Mutual, for:

Group Long Term Disability Insurance (With Business Overhead Expense Coverage)

If you elect the option above with Business Overhead Expense coverage as part of your Group Long Term Disability plan, please have the person(s) applying for the coverage complete Part B in its entirety and mail in to the company at the address below:

Address: Lincoln Mutual Life and Casualty
PO Box 1918
Fargo, ND 58107-1918

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms.

FRAUD WARNING: 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.

The statements above are true to the best of my knowledge and belief, and I agree they shall form a part of the policy for which this application is made. The insurance requested with this Evidence of Insurability form will not be effective until approved by the Home Office of Lincoln Mutual. I hereby certify that I have received a copy of this form.

Print Name: _____

Title: _____

Applicant's Signature

Date

Lincoln Mutual
Life and Casualty Insurance Company
APPLICATION FOR GROUP DISABILITY INSURANCE – continued

PART B BUSINESS OVERHEAD EXPENSE COVERAGE APPLICATION – EVIDENCE OF INSURABILITY FORM

Name of Applicant (Last, First, Middle Initial)	Social Security Number
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Please list below the total expenses of the business entity for which you are liable:

YOUR MONTHLY EXPENSES (Bills due and payable each month.)	YOUR PROPORTIONAL EXPENSES (Proportional Expenses are those incurred once or twice a year.)
OFFICE \$ _____ Rent/Lease \$ _____ Telephone \$ _____ Mortgage Interest for Business Property \$ _____ General Office Supplies \$ _____ Postage & Stationery \$ _____ Property Maintenance	PROPERTY \$ _____ Property Taxes
SERVICES \$ _____ Accounting/Bookkeeping \$ _____ Legal \$ _____ Answering Service UTILITIES \$ _____ Oil, Gas, or Electric \$ _____ Water	INSURANCE PREMIUMS \$ _____ Property & Casualty \$ _____ Liability Coverage
BUSINESS \$ _____ Employee Salaries/Benefits Costs \$ _____ Employment Taxes EQUIPMENT \$ _____ Interest or Lease Payments \$ _____ Principal Payment \$ _____ Equipment Maintenance Include: payroll taxes & contributions for employee benefits. Exclude: Salary, fees, drawing accounts, profits, or other forms of remuneration and benefits payable to or for you, anyone hired to replace you, any other owners of the business, anyone employed by the employer who does the same type of work as you, or any member of your immediate family not regularly employed by the business, whether or not they were employed by the business prior to disability	PROFESSIONAL \$ _____ Licenses \$ _____ Membership Dues \$ _____ Subscriptions \$ _____ Miscellaneous
\$ _____ TOTAL monthly	\$ _____ TOTAL Proportional

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Print Name: _____

Title: _____

 Applicant's Signature

 Date

Lincoln Mutual
Life and Casualty Insurance Company

(Continued)

PART B BUSINESS OVERHEAD EXPENSE COVERAGE INFORMATION (Only Applicable with LTD Coverage)

The following information must be provided for each employee applying for business overhead insurance:

Type of Organization: Sole Proprietorship Corporation Partnership
 Limited Liability Corporation (LLC)

Employee Name: _____

BOE Benefit Period: 12 Months 24 Months

Indicate the monthly benefit desired: (Benefits will be paid to the business and will not exceed the actual amount of the business overhead expense benefit actually paid by the insured each month)

Percent of the Employee's Monthly Earnings to be used to calculate benefits:

10% 15% 25%

Monthly Maximum:

\$2,000 \$3,000 \$5,000

Note: Each person applying for business overhead coverage must complete Part B of the small group application (Business Overhead Expense Coverage Application), and submit it to the company prior to any approval being granted for the coverage.

Applications must be completed, signed and returned by mail to:

Lincoln Mutual Life and Casualty
PO Box 1918
Fargo, ND 58107-1918

Lincoln Mutual
Life and Casualty Insurance Company
INFORMATION PRACTICES NOTICE

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, consumer reporting agencies, employers, or the Medical Information Bureau, Inc. (MIB). We will use the authorization you signed on the front side of this form when we seek this information.

MEDICAL INFORMATION BUREAU (MIB)

Information we collect about you is confidential. However, we may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such a member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. We may also release information about you to other insurance companies to whom you have applied for life or health insurance or made claim for benefits.

MIB will disclose any information it has about you at your request.

If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. The address of the MIB Information Office is: P. O. Box 105, Essex Station, Boston, Massachusetts 02112. MIB's telephone number is (617) 426-3660. Your request for correction will be handled by MIB in accordance with the procedures outlined in the Federal Fair Credit Reporting Act.

FEDERAL FAIR CREDIT REPORTING ACT PRENOTIFICATION

As part of the underwriting process, we may request an Investigative Consumer Report. These reports are prepared by independent reporting firms. They provide pertinent information about character, general reputation, personal characteristics, health, finances, and mode of living. This information may be obtained through personal interviews with friends, neighbors, associates, or others who know you.

If we request an Investigative Consumer Report, you have the right to ask to be interviewed personally. Upon your written request, you have the right to receive a copy of the report from the reporting company. If a report affects our decision not to approve your application as requested, we will provide you with the name and address of the reporting firm.

DISCLOSURE TO OTHERS

The information collected about you is confidential. We will not release any information about you without your authorization except to the extent necessary to conduct our business or as required or permitted by law.

YOUR RIGHTS

You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, please write us.

Lincoln Mutual Life and Casualty
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Please retain a copy for your records of the Health Statement and this Notice.