DISABILITY INCOME BENEFITS

Policy Form HPDI2002 or State Edition

Professional Insurance Company

In California, PIC Life Insurance Company

Protect your most valuable asset…Your Income.

You spend a long time building up your sick leave, but one injury or illness can wipe it all out. With a Disability Income Plan from Professional Insurance Company you can receive a monthly income while you are unable to work due to a covered injury or sickness.

If you are hospitalized for a covered sickness, benefits will begin on the first day admitted.

Your maximum benefit period is based on the number of policy years your policy has been in force:

Policy Years	0	1	2	3 or 4	5 and over
Maximum Benefit Period	12 months	13 months	14 months	15 months	18 months

If your gross monthly income is at least:	Maximum Monthly Benefit you can choose:	1st Day Accident 8th Day Sickness (semi-monthly)
835	**$500.00**	13.75
1,000	**$600.00**	16.50
1,167	**$700.00**	19.25
1,335	**$800.00**	22.00
1,500	**$900.00**	24.75
1,666	**$1,000.00**	27.50
1,833	**$1,100.00**	30.25
2,000	**$1,200.00**	33.00
2,166	**$1,300.00**	35.75
2,333	**$1,400.00**	38.50
2,500	**$1,500.00**	41.25
2,666	**$1,600.00**	44.00
2,833	**$1,700.00**	46.75
3,000	**$1,800.00**	49.50
3,166	**$1,900.00**	52.25
3,333	**$2,000.00**	55.00
4,166	**$2,500.00**	68.75
5,000	**$3,000.00**	82.50

First Hospital Confinement Rider

(HRFHC) Pays the Benefit Amount for the insured's first hospital confinement for a covered injury or sickness during the calendar year based on the total number of days of hospital confinement during the period of confinement. The benefit is not cumulative and will not exceed $5,000.00

One day $500.00
Two Days $1,000.00
Three Days $2,000.00
Four Days $3,000.00
Five Days $4,000.00
Six or more days $5,000.00

Emergency Accident Rider

(HREA) Pays the Benefit Amount selected for Emergency Care due to a covered injury rendered within 72 hours by a physician in a hospital emergency room or a physician's office. Pays for up to 4 different covered injuries for each calendar year per insured category. (4 for employee, 4 for spouse, and a combined total of 4 for all children.)

$ 100.00 Benefit Amount

Optional Rider

Employee 6.82 Spouse 6.82 Children 4.07

Plan pays 50% of the benefit amount if Workers' Compensation pays.

Waiver of Premium – All premiums that are due after you have received disability benefits for 90 days will be waived for as long as benefits are payable at no additional charge.

For more information, contact:

David Dearie
(504) 616-3537

Email: Dearie@cox.net Website: www.daviddearieinsurance.com

GR/1807
09/07

DEFINITIONS

Injury/Injured: Bodily injuries sustained which: a. are directly caused by an accident, independent of all other causes (In Illinois, independent of disease or bodily infirmity); and b. have not been specifically excluded by name or description in this Policy; and c. are not caused or contributed to (In Illinois, or contributed to does not apply) by Sickness (Not applicable in Pennsylvania); and d. occur while this Policy is in force for You. (In Maryland, if the injury occurs before the Policy Effective Date, it will be covered under this Policy if Disability begins after 12 months from the Policy Effective Date.)

Sickness: Disease or illness, including pregnancy, which: 1) is diagnosed or treated while this Policy is in force for the Insured (Not applicable in Tennessee); and 2) does not result from Pre-existing Conditions as defined; and 3) has not been specifically excluded by name or description in this Policy. (In Maryland, if the sickness manifest itself before the Policy Effective Date, it will be covered under this Policy if Disability begins after 12 months from the Policy Effective Date.)

Totally Disabled or Total Disability: Total disability must be due to a covered Injury or covered Sickness. You are totally disabled when You are: 1) unable to perform the Material and Substantial Duties of Your Regular Occupation during the Elimination Period and the following 2 years; thereafter, it means Your inability to perform the duties of any occupation for which You are reasonably suited by education, training or experience (In Louisiana, and which provides substantially the same earnings capacity as prior to the start of the disability); and 2) not performing any work or service for pay. (In Kansas, not performing any work or service for pay for which You are reasonably suited by education, training, or experience.)

You must be Employed when total disability begins. Benefits for total disability will not be paid if You are not Employed when total disability begins (In Iowa employment when total disability begins is not applicable). Proof of total disability will be required. You must be under the Regular Care of a Physician. This does not apply if the Physician tells Us and We agree that Regular Care would be of no further benefit to You. (In Iowa you must be under the care of a physician.) (In Maryland, a presumptive disability is classified as a total disability.)

RENEWABILITY

This Policy is guaranteed renewable to age 70 subject to the terms and conditions of the Policy. You may renew this Policy until the Policy Anniversary date on or after Your 70th birthday if You pay the Premium when due or within the Grace Period. We have the right to change Premiums at any time. (In Massachusetts, rates for accident riders are guaranteed for the life of the rider; In Montana, may not be increased more than once during a 12 month period; In North Carolina, new rate will be guaranteed for not less than 12 months; In Louisiana, Premium rates are guaranteed for the first 12 months. After the initial 12 month period, We have the right to change Your Premiums but not more than once in any 6 month period; In Oregon, with the approval of the new rate by the Oregon Insurance Division.) If We do change the Premiums, We will do so only: a. if We change the Premiums for all policies of this same form (In Washington, similar policies of this form) and issue age in Your state of issue; and b. if it is within the laws and regulations of Your state of issue; and c. if We give You 60 days notice in writing before such change becomes effective. Any change in the Premium will be based on Your age and occupation class as of the Policy Effective Date.

LIMITATIONS & EXCLUSIONS

PART I.

This Policy (including any Rider(s) attached) does not cover losses sustained while, caused by, contributed to (In Illinois, contributed to does not apply), or resulting from:

a. (In Maryland, The Insured) being legally intoxicated as defined by state law where the loss occurred (Not applicable in Oklahoma; In South Carolina, where the insured resides) or (In Wisconsin, intentionally) being under the influence of any narcotic unless administered on the advice of a Physician (Not applicable in Connecticut, Michigan, South Dakota or Washington; In Idaho, General Provision applies: Intoxicants and Narcotics: We shall not be liable for any loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any narcotic unless administered on the advice of the Physician); or
b. alcoholism or drug addiction (Not applicable in South Dakota or Maryland); or
c. attempted suicide while sane or insane (or insane not applicable in Missouri) or intentionally self-inflicted Injury (In Colorado, suicide or attempted suicide while sane or intentionally self-inflicted Injury while sane); or
d. Mental or Nervous Disorders; or
e. being exposed to war or any act of war, declared or undeclared or while serving in the armed forces (In Oklahoma, any war or act of war, declared or undeclared or while serving in the armed forces or any auxiliary unit attached thereto); or
f. (In Maryland, Insured) engaging in an illegal activity (Not applicable in Connecticut). (In Idaho and Oklahoma, participation in a felony, riot or insurrection; In South Carolina, engaging in an illegal occupation or committing or attempting to commit a felony; In Maryland, Insured engaging in an illegal occupation or the Insured participation in the commission of or attempt to commit a felony; In Connecticut, participation in a felony, riot or insurrection) (In Iowa engaging in an illegal activity or incarceration); or
g. participation in any form of aviation other than as a fare-paying passenger in a fully licensed passenger carrying aircraft; or
h. voluntary inhalation of gas (Not applicable in Connecticut, Idaho and Oklahoma); or
i. sky diving, hang gliding, mountaineering and bungee jumping (Not applicable in Idaho, Oklahoma, South Carolina, Virginia or Washington); mountaineering and bungee jumping (In Iowa not applicable) or
j. riding in or driving any motor-driven vehicle in a race, stunt show or speed test (Not applicable in Idaho, Iowa, Oklahoma, South Carolina, Virginia or Washington); or
k. conditions specifically excluded by amendment or Endorsement; or
l. any Pre-Existing Conditions as defined in this Policy (Not applicable in Connecticut; In Maryland, for 12 months).

For the Specified Injury Rider, the following are added to Part I above: (Limitations below not applicable in Idaho, Iowa, Oklahoma, South Carolina, Virginia, or Washington; In Connecticut and West Virginia, Specified Injury Rider not available)

a. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
b. driving a car or any other licensed vehicle on a highway without a valid operator's license; or
c. mountaineering, sky diving, hang gliding or bungee jumping; or
d. Insured Dependent(s) practicing for or participating in any high school, college, semi-professional or professional competitive athletic contest. This does not apply to intramural sports.

PART II.

This Policy (including any Rider(s) attached) does not pay Benefits for:

a. care that is primarily for: 1) rest; or 2) convalescence; or 3) rehabilitation (3 not applicable in Idaho); or
b. treatment which is rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or Injury sustained while traveling for business or pleasure; or
c. Total or Partial Disability while You are outside of the United States, its possessions, or Canada; or
d. Dental Treatment or plastic surgery for cosmetic purposes. This exclusion does not apply if the treatment or surgery (In Illinois, reconstructive surgery) is: (1) due to an Injury (In Illinois, incidental to or follows surgery due to an Injury, infection or other diseases of the involved part); or (2) to restore normal bodily functions; (In Idaho, This exclusion does not apply if the treatment or reconstructive surgery is: (1) incidental to or follows surgery due to Injury, Infection or other diseases of the involved part; or (2) to restore normal bodily functions (In Maryland, benefits will be paid for complications that occur during the surgery that have not been excluded in any part of this policy); or (3) for congenital disease or anomaly of a newborn Eligible Dependent Child) or
e. Total or Presumptive Disability that begins while not Employed. (Not applicable in Iowa and Idaho)
f. (In Maryland, payment of health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.)

We will not pay Benefits (In Idaho, Disability Benefits) for any period the Insured is incarcerated in any type of penal institution (Not applicable in Iowa and South Carolina).

PRE-EXISTING CONDITIONS

This Policy and any attached Rider(s) do not cover pre-existing conditions whether disclosed in the application or not (Not applicable in Maryland) (In Wisconsin, any condition noted in the application and not specifically excluded in any part of the contract is not a pre-existing condition) for any loss that occurs during the first 12 months (In New Mexico, 6 months) beginning on the date the person becomes an Insured under this Policy or Rider. Any Disability resulting from a pre-existing condition will not be covered if it begins (In South Dakota, if it begins does not apply) during the first 12 months (In New Mexico, 6 months) after the Policy Effective Date. Refer to When a Recurrent Disability Becomes a New Disability section for a Recurrent Disability from a pre-existing condition.

By a pre-existing condition, We mean a condition for which a Physician prescribed, recommended or gave to the Insured during the 12 months (In Idaho, New Mexico and Wyoming, 6 months) before the Insured's Policy/Rider Effective Date: 1) treatment; or 2) medical advice; or 3) consultation; or 4) diagnosis or diagnostic tests; or 5) medication.

Childbirth (including cesarean) within 10 (in Maryland 9) months of the date the person becomes an Insured under this Policy or Rider will be considered a pre-existing condition. (In Montana, pregnancy prior to Policy Effective Date is a pre-existing condition; In Iowa or Washington, childbirth exclusion does not apply to complications of pregnancy. In Idaho, Pregnancy existing for an Insured on the Policy/Rider Effective Date will be considered a pre-existing condition.) (In North Carolina, for any person age 65 and over when they become insured, pre-existing conditions means only those conditions specifically excluded in the Policy or endorsement.)

Conditions specifically named or described as excluded in any part of this Policy are never covered (in Maryland, any condition noted in the application and not specifically excluded by signed waiver, is not considered a pre-existing condition).

Licensed Agent: ______________________________

Product underwritten by Professional Insurance Company (In California, PIC Life Insurance Company), 175 Addison Road, Windsor, CT 06095

This brochure is presented as a matter of general information and is not a contract of insurance. Benefits are only available after the Effective Date of the Policy. For specific details about Benefits, including Definitions, Limitations and Exclusions, refer to Policy Form HPDI2002 (or state edition). Plans may vary by state and are not available in all states.

Professional Insurance Company | **Application For Insurance**

FRAUD: 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 (in Oregon and Nebraska "may be") a crime and subjects (in Oregon and Nebraska "may subject") such person to criminal and civil penalties.

❑ **Check if replacing or changing existing coverage in this company. Policy Number** ______________________________

PERSONS PROPOSED FOR INSURANCE

Last Name First Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security No.
	Primary Insured	/ /				– –
	Spouse	/ /				
	Child	/ /				COMPLETE SHADED
	Child	/ /				AREAS IF AVAILABLE
	Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Addressee	City	State	Zip	Home Telephone ( )
Employer	Date Employed		Hours Worked/Wk	
Occupation / Monthly Income $	Group Number		Employee/Payroll Number	
Payor or Owner if other than Primary Insured ❑ Payor ❑ Owner	Social Security No. – –		Relationship To Primary Insured	
Beneficiary			Age	Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities, and been actively at work full time at their regular occupation? ____Yes ____No. If "No", explain: ______________________________

USED TOBACCO in the past 12 months? Primary Insured ____Yes ____No Spouse ____Yes ____No

DO YOU have any existing Life Insurance or Annuity policies. ____Yes ____No. **DO YOU** plan on replacing or changing any existing Life or Health Insurance policies in this or any other company? ____Yes ____No. If "Yes", complete replacement form where required.

INSURANCE PLANS

Monthly Premium

DISABILITY Primary Insured Only

	Occ. Class		Monthly Ben	Elim. Period	Ben. Period	Building Ben. Rider	50% Ben. Red. unless % selected here ________
❑ HPDI2002		Injury	$________	________	________	❑	
❑ ________	❑ 1 ❑ 2	Sickness	$________	________	________		

RIDERS

	AD&D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpat. Sick.	Spec. Inj.	1st Hosp. Conf.	________
Primary Ins.	$______	$______	$______	$______	$______	❑	❑	$______
Spouse	$______	$______	$______	$______	$______	❑	❑	$______
Children	$______	$______	$______	$______	$______	❑	❑	$______

$________

HOSPITAL

		Base Policy	RIDERS: AD&D	Emerg. Acc.	Hosp. Inj.	ICU	Lump Sum	Outpat. Sick.
❑ 0/0 180	Primary Ins.	$______	$______	$______	$______	$______	$______	$______
❑ 0/0 365	Spouse	$______	$______	$______	$______	$______	$______	$______
❑ 0/3 365	Children	$______	$______	$______	$______	$______	$______	$______

RIDERS

	Private Nurse	Surgical	Surgical+	Spec. Inj.	1st Hosp. Conf.	________	________
Primary Ins.	$______	$______	$______	❑	❑	$______	$______
Spouse	$______	$______	$______	❑	❑	$______	$______
Children	$______	$______	$______	❑	❑	$______	$______

$________

CANCER

Base Policy $______
❑ Primary Ins.
❑ Family

RIDERS

Surgical	Physician Att.	ICU
$______	$______	$______
Can. ICU	**Chemo**	**Hospice**
$______	$______	$______

❑ **Comp. Care**
First Occurrence
❑ $500
❑ $1000

Disability Income $500
(Primary Ins. Only)
❑ 6 Month Benefit
❑ 1 Yr Benefit

$________

LUMP SUM CANCER

❑ Individual ❑ 1 Parent ❑ 2 Parent **Max. issue in GA is $30,000**

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

$________

LIFE

❑ LPRT2002 Amount $____________ ❑ Accidental Death Rider ❑ Waiver of Premium

❑ ________ ______ Units Family Rider ______ Units Children's Rider ❑ Other____________

$________

1.HAS ANY PROPOSED INSURED:

A) In the last 10 years been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? ____Yes _____No.

B) Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? ____Yes ____No.

C) In the past 2 years had a driver's license suspended/revoked? ____Yes(License #_________________ State ________) ____No.

2. IS ANY PROPOSED INSURED currently covered or eligible for Medicare? ____Yes ____No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any Proposed Insured age 65 or over.

D1. FOR DISABILITY COVERAGE: List the amount of any other individual disability insurance currently applied for or in force for the primary insured $_________________

C1. FOR CANCER COVERAGE: Has any proposed Insured in the last 10 years been treated for or been diagnosed as having: Cancer or any malignancy; Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Malaria; Bubonic Plague; Smallpox; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Meningitis; Undulant Fever; Rocky Mountain Spotted Fever; Hansen's Disease; Addison's Disease; Sickle Cell Anemia; Tularemia; or Typhoid Fever? ____Yes ____No

L1. FOR LIFE COVERAGE, HAS ANY PROPOSED INSURED IN THE PAST 3 YEARS:

A). Used any illegal, restricted, or controlled substance or narcotics except by doctor's prescription or been advised to seek, or received treatment or counseling for alcohol or other drug use? ____Yes ____No

B). Had an application for insurance or reinstatement that was declined, postponed, rated up or modified? ____Yes ____No

C). Had or been treated for any disease of the lungs, blood, brain, heart, blood vessels, kidneys, pancreas, or liver or had or been treated for high blood pressure, paralysis, cancer, or tumor? ____Yes ____No

Details of "Yes" Answers in 1,D1,C1 or L1. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Insurance Information Practices: This notice describes the practices we, Professional Insurance Company, and your agent follow to manage your personal information. We will rely on the information you, the Primary Insured, provide in this application to decide if you and your dependents are insurable. We or your agent may telephone you to confirm information given in this application or to obtain additional information needed to process your application. Before asking other sources for information about you or your dependents, we will get your written authorization. Information you provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about you and your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request our detailed Description of Information Practices by writing to us at P.O. Box 80637, Lincoln, NE 68501-0637.

Agreement: I have read, or had read to me the completed application and agree that 1)all statements and answers about me and other proposed insureds are complete to the best of my knowledge and belief; 2) all statements and answers have been truly and accurately recorded; 3) acceptance of any policy issued on this application will constitute a ratification of any corrections and/or additions to the application by us in the section called "Home Office Corrections and/or Additions" for administrative purposes; 4) this application shall be part of any policy issued; 5) any false statement or misrepresentation herein may result in loss of coverage(s) subject to the Time Limit on Certain Defenses under the Policy; 6) any coverage(s) will be effective on the Policy Effective Date recorded on the Policy Specifications Page of the Policy, not the date the application is signed; 7) all exceptions, limitations, and pre-existing conditions pertaining to the coverage(s) applied for have been explained; 8)no person(s) to be covered for a specified disease is also covered by any Title XIX program (Medicaid or any similar name); and 9) the agent is not authorized to make or modify contracts, waive any Company rights or requirements, or waive any information the Company requests.

Home Office Corrections and/or Additions Only

X ______________________________ Signed at ____________________ on _____/_____/20_____

Signature of Primary Insured (Parent if person to be insured is less than 15 years old) — City, State — Date

X ______________________________ X ______________________________

Signature of Owner (If other than Primary Insured) — **Spouse**

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge that the insured: 1) ❑ does ❑ does not have any existing Life Insurance or Annuity Policies; or 2) replacement of a Life or Health Policy ❑ is ❑ is not involved at this time.

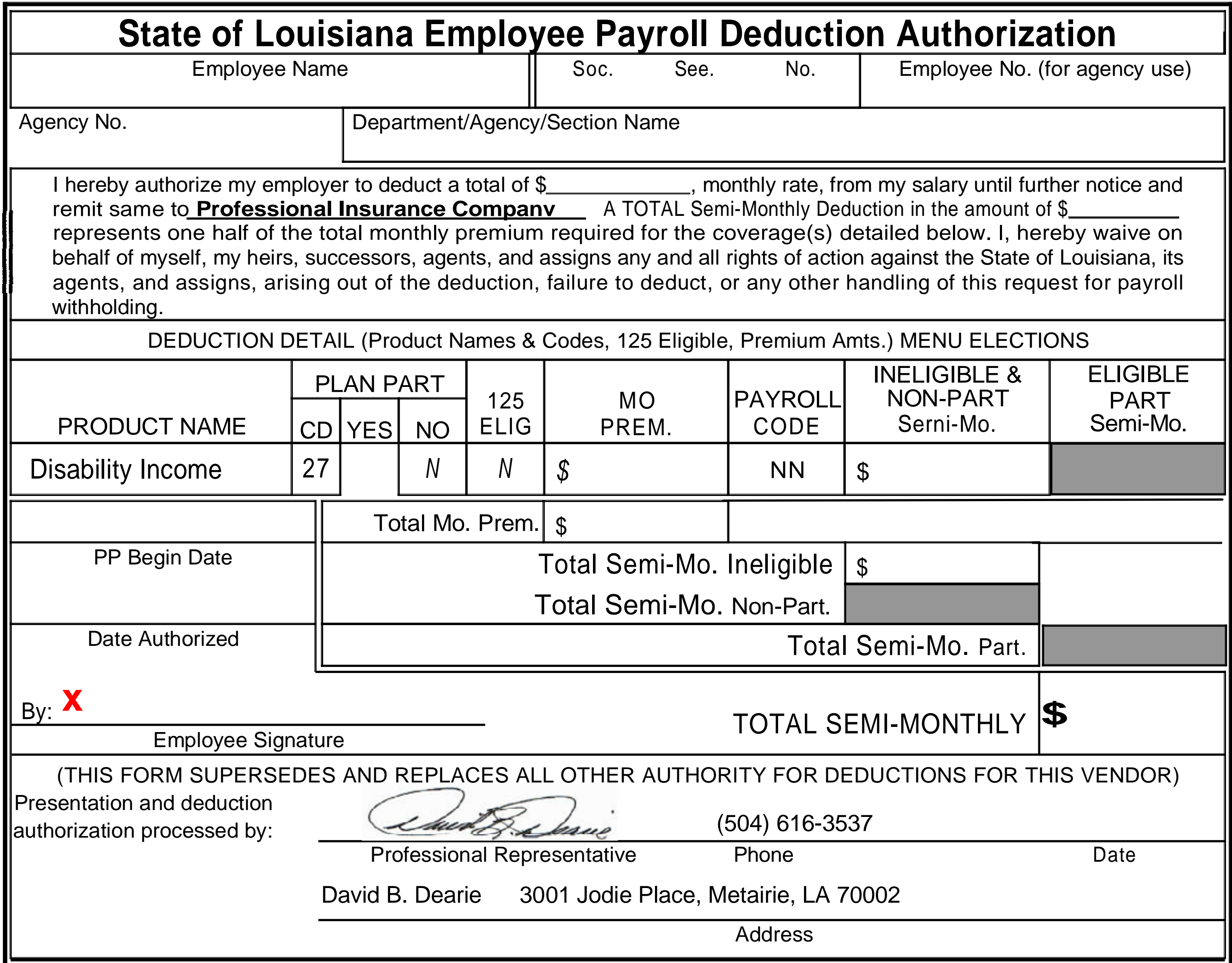
X ______________________________ _____/_____/20_____ ____________ _____ % ____________

Signature of Agent — Date — Agent's No. — % Credit — State ID No.

SED-4 (R 04/06)

Professional Insurance Company

In California, PIC Life Insurance Company



State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. See. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $____________, monthly rate, from my salary until further notice and remit same to **Professional Insurance Company** A TOTAL Semi-Monthly Deduction in the amount of $__________ represents one half of the total monthly premium required for the coverage(s) detailed below. I, hereby waive on behalf of myself, my heirs, successors, agents, and assigns any and all rights of action against the State of Louisiana, its agents, and assigns, arising out of the deduction, failure to deduct, or any other handling of this request for payroll withholding.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART			125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
	CD	YES	NO					
Disability Income	27		N	N	$	NN	$	

Total Mo. Prem.	$
Total Semi-Mo. Ineligible	$
Total Semi-Mo. Non-Part.	
Total Semi-Mo. Part.	
TOTAL SEMI-MONTHLY	$

PP Begin Date

Date Authorized

By: X ______________________

Employee Signature

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

Professional Representative	Phone	Date
[signature]	(504) 616-3537	

David B. Dearie 3001 Jodie Place, Metairie, LA 70002

Address