

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

INSTRUCTIONS FOR AGENTS/BROKERS

BE SURE TO ASK ALL QUESTIONS AND RECORD THE ANSWERS IN DARK PEN. DO NOT USE PENCIL. If, for some reason, a question is not applicable, please indicate that on the application. If an answer needs to be changed, DO NOT USE WHITE OUT. Put ONE line through the incorrect answer and insert the correct information.

All corrections MUST be initialed by the Proposed Insured. Make sure the application is properly dated, the city and state where it was completed are recorded, and that ALL of the necessary signatures are in place before the application is submitted. We will not accept any application that is completed on a photocopy or facsimile.

CONDITIONAL RECEIPT: Give the Conditional receipt to the applicant in exchange for premium payment. Do not take any money unless you give the applicant the Conditional Receipt. You do not have any authority to alter or waive the conditions set forth in the Receipt.

If the Conditional Receipt is given, the first modal premium (2 months for check-o-matic) for the plan and amount of insurance which may become effective prior to policy delivery must be collected.

Be sure the applicant understands the terms of the Conditional Receipt, in particular, the “CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY.”

The premium must be paid by check or money order. The check or money order must be made payable to Presidential Life Insurance Company ONLY. Full amount collected must be entered in Section IV, Question 4 of the application.

IMPORTANT: If money is not received with the application, the Conditional Receipt must not be detached from the application.

PROPOSAL: If available, a copy of the proposal or rate calculation should be included with the application.

FINANCIAL DOCUMENTATION: Financial documentation should be submitted with the application.

FINANCIAL DOCUMENTATION REQUIREMENTS:

	Employees	Sole Proprietor	Partnership	S-Corp	C-Corp
Forms Required	Paycheck stub, W-2, or Form 1040, and bonus verification, if applicable	Form 1040 and Schedule C	Schedule K-1 of Form 1065 or Schedule E of the Form 1040	Form 1120S, W-2 and either Schedule K-1 of the 1120S or Schedule E of the Form 1040	Form 1120, Pages 1 and 2, and Form W-2
Definition of Earned Income	Gross Wages (W-2), Employee's Pension/Profit Share Contribution, and verifiable bonuses	Net profit of the business after expenses.	The applicant's proportionate share of the net profit.	Gross Wages (W-2), Pension/Profit Share Contribution and share of corporate net income.	Gross Wages (W-2), Pension/Profit Share Contribution and share of corporate net income.

Mailing Instructions

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE

I hereby apply for insurance based on the following representations:

SECTION I. Personal Information

Full Name of Proposed Insured				
Home Telephone No. ()			Social Security No.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Height _____ft. _____in.	Weight _____lbs.	Date of Birth
Birthplace	Age	Send Notice to: <input type="checkbox"/> Residence <input type="checkbox"/> Business		
Residence Address				
City/State/Zip		Phone No.	How Long? (If less than 5 years give previous address below)	
Previous Residence Address		City/State/Zip		
Business Address		City/State/Zip	Phone No. ()	
Name of Current Employer		Occupation (Job Title)	How Long? (If less than 5 years name and address of previous employer below)	
Previous Employer – Name and Address				
Duties			Earned Annual Income	
Beneficiary name			Relationship to Insured	

SECTION II. Medical Information

- Have you received medical advice or been confined to a hospital, nursing home or similar establishment or been disabled within the last 12 months? Yes No
- To the best of your knowledge and belief have you ever been treated for or ever had any known indication of (a) high blood pressure, diabetes, cancer, arthritis, asthma, emphysema, or emotional, nervous or mental disorder, or disease or disorder of the eyes, ears or speech? Yes No
- Have you ever been diagnosed by, or received treatment from, a licensed physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune disorder? Yes No
- Have you ever used barbiturates, narcotics, excitants or hallucinogens, or ever sought help or treatment for their use or alcohol use? Yes No
- Other than above, have you, within the past five years, had medical or surgical advice or treatment, had a physical examination, or been under observation for any disease or disorder? Yes No

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NYACK, NEW YORK**

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE

I hereby apply for insurance based on the following representations:

SECTION I. Personal Information

Full Name of Proposed Insured				
Home Telephone No. ()			Social Security No.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Height _____ ft. _____ in.	Weight _____ lbs.	Date of Birth
Birthplace	Age	Send Notice to: <input type="checkbox"/> Residence <input type="checkbox"/> Business		
Residence Address				
City/State/Zip		Phone No.	How Long? (If less than 5 years give previous address below)	
Previous Residence Address		City/State/Zip		
Business Address		City/State/Zip	Phone No. ()	
Name of Current Employer		Occupation (Job Title)	How Long? (If less than 5 years name and address of previous employer below)	
Previous Employer – Name and Address				
Duties			Earned Annual Income	
Beneficiary name			Relationship to Insured	

SECTION II. Medical Information

1. Have you received medical advice or been confined to a hospital, nursing home or similar establishment or been disabled within the last 12 months? Yes No
2. To the best of your knowledge and belief have you ever been treated for or ever had any known indication of (a) high blood pressure, diabetes, cancer, arthritis, asthma, emphysema, or emotional, nervous or mental disorder, or disease or disorder of the eyes, ears or speech? Yes No
3. Have you ever been diagnosed by, or received treatment from, a licensed physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune disorder? Yes No
4. Have you ever used barbiturates, narcotics, excitants or hallucinogens, or ever sought help or treatment for their use or alcohol use? Yes No
5. Other than above, have you, within the past five years, had medical or surgical advice or treatment, had a physical examination, or been under observation for any disease or disorder? Yes No

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6. Give details of "Yes" answers to 1-5. Include diagnoses, dates, physicians and addresses.

7. Please provide the Name(s) and Address(s) of Your personal physician(s) or health care facility(ies).

SECTION III. General Information

1. Are you gainfully employed outside the home for a minimum of 30 hours per week and have been so for the past year? If no, please explain Yes No
2. Have you ever made an application for disability, health or life insurance which has been declined, modified or rated up? (If yes, give names of organization, kinds of insurance, dates and reason.) Yes No
3. To the best of your knowledge and belief do you have a physical impairment or deformity? Yes No
4. Have you ever made claim or received benefits for disability from any source? Yes No
5. Are you presently taking any prescribed medication? Yes No
6. Have you used any tobacco products in the past 12 months? Yes No
7. Do you intend to fly other than as a passenger on a commercial airline or have you flown other than as a passenger on a commercial airline in the past 2 years? Yes No
8. Have you in the past 2 years engaged in, or do you expect to engage in an extra hazardous activity such as hang gliding, racing (automobile, go-karts, cycle, boat, snowmobile) or diving (skin, scuba, sky)? Yes No
9. Give details of "Yes" answers to 1-8.

10. Disability income insurance in force: (if none, so state). Is replacement intended? Yes No
If yes please explain: _____

Company Name	Mo. Benefit	Benefit Period	To Be Replaced or Changed?	Policy Number
			Yes <input type="checkbox"/> No <input type="checkbox"/>	
			Yes <input type="checkbox"/> No <input type="checkbox"/>	

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this authorization.

COMPANY: Presidential Life Insurance Company

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency

BUREAU: Medical Information Bureau, Inc.

AUTHORIZATION: Authorization to Obtain and Disclose Information

I understand that the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organizations; (7) financial source; and (8) employer, to give the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits. These facts may include details of alcohol and/or drug use, abuse, and/or treatment. The Company and its reinsurers will use the information in order to determine whether I am insurable.

Those parties named in the first paragraph of this Authorization, excluding insurance support organizations, may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. Insurance support organizations may disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law.

This Authorization will be valid for two years after the date of signing. I understand that I, or my authorized representative, may request to receive a copy of this Authorization. I authorize the Company to procure an investigative consumer report, if required.

Signed at _____ this ____ day of _____, 20 ____

Signature of Proposed Insured

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SECTION VI. CONDITIONAL RECEIPT

This receipt is to be issued only if payment is made at the time the application is signed; otherwise, it must not be detached.

Unless the conditions specified in Paragraph "FIRST" are fulfilled exactly, no insurance will become effective prior to policy delivery. Neither the agent/broker nor the medical examiner are authorized to alter or waive these conditions.

Received from _____ the sum of \$ _____ in connection with this application for disability income insurance to Presidential Life Insurance Company of New York. This receipt bears the same date as the application.

FIRST. CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVER. If the following conditions are fulfilled exactly:

- a. All medical examinations and tests, including X-rays and EKG's, initially required by published Company rules must be completed within 45 days after the date of this receipt and received at its administrative office within 60 days after such date.
- b. An amount equal to the first modal premium for the amount of insurance which may become effective prior to policy delivery must be received with the application
- c. On the date that insurance becomes effective in accordance with the provisions of this receipt, each person to be covered must be insurable for the plan and the amount of insurance applied for without modification and at the rate of premium paid.

then insurance as provided by the terms and conditions of the policy applied for and for an amount not exceeding that specified in the Application will become effective on the latest of the following dates, on either the 1st or 15th of the following month: (a) the date of this application; (b) the date that the last of the medical examinations and tests that were initially required are completed; and (c) the Date of Issue, if any, requested in the application. Any insurance applied for as alternate or additional to the plan and amounts of insurance applied for in the application will not become effective under this conditional receipt.

SECOND. RETURN OF AMOUNT REMITTED. The sum paid in exchange for this receipt will be returned upon demand and surrender of this receipt and on insurance will become effective if: (a) all of the conditions specified in Paragraph "FIRST" are not fulfilled exactly; (b) the Company declines the application; or (c) the application contains any material misrepresentation(s). This sum will also be returned upon written request received at its administrative office before the policy is delivered.

The receipt is not valid unless signed by the Proposed and the owner, if different, and the agent/broker who receives payment. **MAKE CHECK OR MONEY ORDER PAYABLE TO PRESIDENTIAL LIFE INSURANCE COMPANY. DO NOT MAKE CHECK OR MONEY ORDER PAYABLE TO THE AGENT/BROKER OR LEAVE THE PAYEE BLANK.** Any check or money order given in payment must be honored on the first presentation for payment. If you do not hear from the Company regarding the proposed insurance with 60 days, notify the Company at its Administrative Office at (866) 747-5677. Give the name of the agent/broker, date and amount paid.

I (We) have read this receipt and understand the CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY (Paragraph "FIRST").

Signed at _____ this _____ day of _____, 20____

Signature of Proposed Insured

Signature of Agent/Broker

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

SECTION VII. NOTICE TO PROPOSED INSURED

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the Company within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and, if so, you will be advised of the name and address and telephone number of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely primarily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report by contacting the consumer reporting agency as explained in the Federal Fair Credit Reporting Act Notice.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of Presidential Life's and your agent/broker's information practices. If you would like to receive a more detailed explanation of those practices, please send your request to the Director of Underwriting, Presidential Life Insurance Company, at its Administrative Office at (866)747-5677.

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. Presidential Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an informational exchange bureau 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 it may have 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 the 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, Tel. (617) 426-3660.

Presidential Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

General Notice

In the course of evaluating and handling each application for insurance, the Company relies primarily on the information provided by you; therefore, you must provide true, complete, and accurate information on the application. Although the Company does not always do so, it may also seek information from other sources. Any information that it obtains from these sources may not be current or complete or accurate however. Consequently, you must inform the Company, prior to delivery of any policy, of any change to any answer on your application. Please review your application for accuracy after all parts have been completed. Any policy that is delivered to you may be contested for a period of two years after the date of issue; this period is referred to as the contestable period. A contest may result if your application is incomplete or if it contains false statements or misrepresentations. Any policy that is delivered to you may be voided and coverage or benefits may be lost as the result of a successful contest within the contestable period. Also, be sure to inform the Company of any changes to any answers on your application that occur before any policy is delivered. In so doing, you can facilitate the issue of your policy and the commencement of coverage.

**PRESIDENTIAL LIFE INSURANCE COMPANY
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PRIVACY NOTICE

Personal information may be collected from persons other than You. Such information, as well as other personal or privileged information subsequently collected by us or Your broker may in certain circumstances be disclosed to third parties without authorization and to affiliates of the company only as permitted by law. You have a right of access and correction with respect to all personal information collected. A detailed notice of information practices will be furnished to You upon request.

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

AUTHORIZATION AND CONSENT FOR BLOOD, URINE OR ORAL FLUID TESTING FOR HIV INFECTION

For the purpose of determining your insurability, the insurance company named above (the "Insurer") has requested that you provide a sample of your blood, urine, or oral fluid for testing. Your blood, urine, or oral fluid will be tested to determine whether you have been infected with Human Immunodeficiency Virus ("HIV"), the virus that causes Acquired Immunodeficiency Syndrome, commonly called "AIDS."

A licensed laboratory will perform a series of tests to determine whether there are antibodies to HIV present in your blood, urine, or oral fluid. Such antibodies are produced by the body in response to HIV infection. If your blood, urine, or oral fluid sample contains such antibodies, this is evidence you are infected with HIV.

The HIV antibody test detects only HIV infection, not AIDS. AIDS is a complex of medical conditions and can only be diagnosed by medical evaluation. Having HIV infection does not mean you have AIDS. However, a person with HIV infection does have an extremely high likelihood of developing AIDS or AIDS-related illnesses. Therefore, if your blood, urine, or oral fluid test result indicates you have HIV infection (this is called a "positive" test result), you may wish to consider further independent testing and follow-up medical evaluation.

By law, your blood, urine, or oral fluid test results must be treated as confidential information. In connection with your application for insurance, certain confidential disclosures will occur. The test results will be reported by the testing laboratory to the Insurer. Also, as necessary in processing your insurance request, the Insurer may confidentially disclose the test results to its employees, reinsurers, affiliates or contractors. If the Insurer is a member of the Medical Information Bureau ("MIB") insurance data bank, the test results may be confidentially reported to MIB, except that only a generic code can be used when reporting non-normal results. This generic code indicates only a non-specific abnormality and does not identify the abnormality as being from an HIV related test.

The Insurer will use your blood, urine, or oral fluid test results to underwrite your application for insurance. A positive HIV test result or other significant abnormality will affect your application for insurance adversely. This means that your application may be declined or that an increased premium may be charged. You may identify on this form the person to whom your specific test results may be disclosed in the event of an adverse underwriting decision. This person may be you, or it may be your physician or other person designated by you in your discretion. Please indicate below the person to whom specific test results should be disclosed (choose one):

To my physician, whose name and address is:

To the following person, whose name and address is:

To me directly. My name and address is:

If your HIV related tests are normal, no routine notification will be sent.

If you want further information about AIDS, the meaning of HIV related test results, or the availability and location of HIV related counseling services, you may call the New York State Department of Health's statewide AIDS hotline number (toll free): 1-800-541-AIDS.

"I have read and I understand this form. I voluntarily consent to the withdrawal of blood, urine, or oral fluid from me by needle, the analysis and testing of my blood, urine, or oral fluid and the disclosure of blood, urine, or oral fluid test results as described above. I understand I have the right to receive a copy of this signed form, and I agree that a photocopy of this signed form will be as valid as the original."

Proposed Insured's Name (print): _____

Proposed Insured's Signature: _____

Date: _____

**PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK**

**Authorization for Release of Health-Related Information
to Presidential Life Insurance Company**

This authorization complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Name of proposed insured/patient (please print)

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Presidential Life Insurance Company and its agents, employees, and representatives. 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, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Presidential Life Insurance Company, or its authorized third parties, Risk Insurance and Reinsurance Solutions, Inc., Disability Insurance Specialists, LLC., and/or its reinsurers, may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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 Presidential Life Insurance Company.

This authorization shall remain in force for 2 years 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 written request for revocation to Presidential Life Insurance Company at its administrative office 1208 W. Newport Center Drive, Suite 202, Deerfield Beach, FL 33442, Attention: Director of Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Presidential Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy 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 My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical records, Presidential Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Insured

Date

PRESIDENTIAL LIFE INSURANCE COMPANY



DIRECT DEBIT AUTHORIZATION

I hereby authorize Presidential Life Insurance Company to initiate debit entries from the account named below to pay premiums on the policy number below. Presidential Life Insurance Company is also authorized to initiate, if necessary, adjustments to the account for any debit or credit entries made by the company in error.

POLICY # _____ INSURED _____

FINANCIAL INSTITUTION NAME _____

BRANCH _____ CITY _____ STATE _____ ZIP _____

TRANSIT/ABA # _____

ACCOUNT # _____

Select one: Checking Savings

NAME(s) on account _____

This authority is to remain in full force and effect until Presidential Life receives written notice of its termination signed by the account holder(s) in such time and in such manner as to afford the company and the depository a reasonable opportunity to act on it.

Signature of account holder Date

Signature of joint account holder (if applicable) Date

**PLEASE ATTACH A VOIDED CHECK FOR CHECKING ACCOUNT
OR
DEPOSIT SLIP FOR SAVINGS ACCOUNT**

ⓄⓄⓄ PLEASE VERIFY ALL ACCOUNT INFORMATION WITH YOUR BANK ⓄⓄⓄ

Presidential Life Insurance Company
Disability Services Division
P.O. Box 86, Bloomfield, CT 06002

Toll-Free Customer Service
1-866-347-7321