UNITED SCHOOLS ASSOCIATES INC.

THE EDUCATORS BENEFITS' COMPANY

16701 Melford Boulevard Suite 400, Bowie, Maryland 20715

Benefit Amount **$3,000** **($3,000 spouse, $1,000 each child)**	◉ **Annual Mode of Premium**	**Mode of Premium Payment** Send Premium Notices Automatic Payment Plan **Day (01-28) of the Month of Draft Bank Account**

Proposed Insured / Applicant

First Name M.I.

Last Name Sex

Address

City State Zip code

Age Last Birthday Date of Birth SS#

Home Phone No. Work Phone No.

Email Address of Proposed Insured/Applicant

School District: _____ School Name: _____ Occupation:_____

Beneficiary Name Relationship

Spouse First Name

Last Name

SS#

Child 1 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Child 2 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Child 3 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Underwritten by:

United American Insurance Company

A Legal Reserve Stock Company * Administrative Office: McKinney, Texas 75070

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Child 4 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Child 5 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Child 6 First Name M.I.

Last Name

SS# Date of Birth (mm-dd-yyy)

Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the applica
Replacement Regulation or Rule. ◯ Yes ◯ No This policy is not to be used to replace other coverage.

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with the respect to and proposed ins
agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed insured is alive; (2) no agent has a
to accept risk or make or change contracts or waive the Company's right or requirements. I understand and agree that the Company reserves the right
the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, the
application is made with the knowledge and consent of the proposed insured.

I, HEREBY AUTHORIZE the MIB, Inc., any insurance, company, hospital, physician or other practitioner having any information available as to my diagn
treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance
Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized
representative may request a copy of this authorization. Information for consumers MIB, Inc. may be obtained on its website of www.mib.com.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containin
or deceptive statement may be guilty of insurance fraud.

Date Application signed

State

_____ Signed_____

Agent's Signature **Proposed Insured**

Last Name Agent no. | | | | | | Signed_____

Print First 5 Letters of Agent's Last Name **Applicant (If other than the Proposed Insured)**

SEND POLICY TO: ◯ Agent ◯ Insured The Policy will be sent to insured unless otherwise instructed.