



Presidential Life Insurance Company

## **INCOME GUARD**

**A Graded Benefit  
Impaired Risk Disability Income Product**

**Field Manual**

**Underwritten by:**

**Risk** *insurance and reinsurance solutions*

**Risk Insurance and Reinsurance Solutions, Inc.**  
**Presidential Life Insurance Company**  
**Income Guard**  
**A Graded Benefit Impaired Risk Disability Income Product**  
**Field Manual**

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**Contacts**

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**Marketing, applications, licensing, underwriting and policy issue contact:**

**Risk Insurance and Reinsurance Solutions, Inc.**  
1208 W. Newport Center Dr., Suite 202  
Deerfield Beach, FL 33442  
(866) 747-5677 Toll Free or (954) 420-4400  
Fax (954) 420-4404

**Website**

<http://NY.impairedrisks.com>

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**Commissions, claims and all other processing contact:**

**Presidential Life Insurance Company  
Disability Services Division**  
P.O. Box 86  
Bloomfield, CT 06002  
(866) 347-7321 Toll Free  
Fax 860-761-1801

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**Forms**

May be downloaded from our website  
<http://NY.impairedrisks.com>

Or call one of the numbers above

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**Summary**

<b>Issue Ages</b>	18-60 age last birthday
<b>Maximum Benefit</b>	\$10,000 per Month Base Benefit plus Social Insurance Substitute Rider Combined based on Income
<b>Minimum Benefit</b>	\$500 per Month Base Benefit plus Social Insurance Substitute Rider Combined
<b>Rates</b>	Male/Female Tobacco/Non Tobacco Level to Age 65 No Occupational Classes
<b>Benefit Period</b>	2 years or 5 years
<b>Elimination Period</b>	60 or 90 Days 180 Days – 5 Year Benefit Only
<b>Renewability</b>	Guaranteed to Age 65 Conditionally to Age 70 (must be actively at work)
<b>Graded Benefit</b>	35% for Disabilities commencing during the 1 <sup>st</sup> Policy Year 75% for Disabilities commencing during the 2nd Policy Year 100% for Disabilities commencing thereafter
<b>Definition of Total Disability</b>	<b>Own Occupation</b> - during the elimination period and during the first 24 months of disability following the satisfaction of the elimination period, <b>Any Occupation</b> for which the Insured is reasonably qualified – thereafter
<b>Mental or Nervous Disorders Limitation</b>	50% of the monthly benefit amount for total disability due to injury or sickness; Monthly benefits are limited to 6 months
<b>Partial Disability</b>	50% of the monthly benefit amount for total disability last paid; Monthly benefits are limited to 6 months
<b>Presumptive Disability</b>	Total and irreversible loss of speech and hearing, sight in both eyes, both feet (amputated at or above the ankle), both hands (amputated at or above the wrist) or one hand and one foot. The monthly benefit amount for the maximum benefit period will be paid whether or not the insured is able to work. The elimination period does not apply to this benefit.
<b>Survivor Benefit</b>	One-time benefit amount equal to 3 times the last full monthly benefit amount paid
<b>Waiver of Premium</b>	After 90 days or the elimination period whichever is longer
<b>Requirements</b>	Actively at work for at least 30 hours per week for the last 12 months and \$40,000 or more per year earnings for the 2 year plan \$60,000 or more per year earnings for the 5 year plan
<b>Riders Available</b>	<b>Occupational Extension Benefit Rider</b> – extends period of own occupation from 2 years to 5 years <b>Social Insurance Substitute Rider</b> – During disability pays while the insured is receiving benefits under the policy and is not receiving benefits under a social insurance plan. Maximum additional \$1,000 per month.

Available in NY only  
Policy Form ISDP2006

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**Description of Benefits**

This is a graded benefit guaranteed renewable to age 65, conditionally renewable from age 65 through age 69, individual disability income insurance policy. Under the guaranteed renewable provision, premiums may be changed for all members of a class, but no more than once in a 12-month period. Conditional renewability is subject to the insured's continuing to be actively at work. On and after age 65, premiums are based on the insured's age on the renewal date. Conditional renewability is subject to the insured's continuing to be actively at work.

Monthly benefits for the duration of a disability beginning in the first policy year will be 35% of the non-graded monthly benefit. For the duration of a disability beginning in the second policy year, the monthly benefit will be 75% of the non-graded monthly benefit. The non-graded monthly benefit will be paid for total disabilities beginning in the 3rd policy year and thereafter.

Total Disability means that because of injury, sickness, or nervous or mental disorder:

1. during the elimination period and during the first 24 months of disability following the satisfaction of the elimination period, the insured is completely unable to perform the material and substantial duties of his (her) regular occupation.
2. following 24 months of receiving monthly benefits, the insured is completely unable to perform the material and substantial duties of any occupation for which he (she) is reasonably fitted by education, training or experience.

The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

In order to receive benefits the insured must be under the care of a physician. This requirement may be waived if there is satisfactory proof that further care is no longer a benefit to the insured.

**Benefit periods offered**

2 years or 5 years

For disabilities beginning at age 60 and after, the duration of the benefit will be in accordance with the following schedule:

Policies with a 2 Year Benefit Period

Disabilities beginning at age 64 and younger	24 months
Disabilities beginning from ages 65 to 69	12 months

Policies with a 5 Year Benefit Period

Disabilities beginning at age 60 and younger	60 months
Disabilities beginning at age 61	48 months
Disabilities beginning at age 62	36 months
Disabilities beginning at age 63	36 months
Disabilities beginning at age 64	24 months
Disabilities beginning from ages 65 to 69	12 months

**Elimination periods offered**

60, 90, or 180 days. The 180 day elimination period is available with 5-year benefit periods only.

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**Presumptive disability**

A presumptive disability provision is included that presumes total disability if an insured suffers total and irreversible loss of speech and hearing, sight in both eyes, both feet (amputated at or above the ankle), both hands (amputated at or above the wrist) or one hand and one foot. The monthly benefit amount for the maximum benefit period will be paid whether or not the insured is able to work. The elimination period does not apply to this benefit.

**Partial disability**

A partial disability benefit is included that pays 50% of the monthly benefit amount for total disability last paid if the insured is partially disabled. Monthly benefits for partial disability are limited to 6 months and will not be paid past the maximum benefit period for total disability.

Partial disability is defined as a disability that immediately follows a period of total disability for which monthly benefits were paid; and, during which, due solely to disability, the insured is able to do one or more, but not all, of the important, substantial and material duties of his (her) own occupation, or results in the loss of 50% or more of the time spent by the insured in the usual daily performance of the duties of his (her) own occupation. The insured must be under the care of a physician.

**Survivor benefit**

If an insured dies as a result of a covered injury, sickness, or nervous or mental disorder, for which he (she) had been receiving disability benefits, and had been Totally Disabled for at least 180 days, his (her) beneficiary will receive a one-time benefit amount equal to 3 times the last full monthly benefit amount paid.

**Waiver of premium benefit**

A waiver of premium benefit is included that provides that after the insured has been totally disabled for the greater of the elimination period as shown in the schedule; or 90 days, premiums will be waived while he (she) remains totally disabled, not to exceed the maximum benefit period. This benefit applies to any additional benefit riders attached to the policy.

**Optional Riders Available**

**Occupational Extension Benefit Rider**

This rider extends own occupation portion of the definition of Total Disability from 2 years to 5 years. This rider is available with 5-year benefit policies only and is only available at time of original policy purchase.

**Social Insurance Substitute Rider**

This rider provides an additional monthly benefit for disability and is only available at time of original policy purchase. The rider pays a monthly benefit if an insured is disabled and receiving monthly benefits under the policy, and is not receiving benefits under a social insurance plan. The monthly benefit payable under this rider is equal to the monthly benefit amount for the rider shown on the policy schedule. Social insurance means benefits provided for disability under Social Security or under any federal or state worker's compensation law or plan or occupational

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disease laws, the Railroad Retirement Act, or Civil Service Retirement Plan. "Social Security" means the federal social security act as now written or as may be amended or replaced.

Social insurance means benefits provided for disability under Social Security or under any federal or state worker's compensation law or plan or occupational disease laws. "Social Security" means the federal social security act as now written or as may be amended or replaced.

**Exclusion Rider**

This rider may be issued based on the medical information, excluding from coverage specified existing medical conditions.

**Extended Elimination Period Rider**

This rider may be issued based on the medical information, extending the elimination period for specified existing medical conditions.

**Exclusions and Limitations**

**Exclusions**

Benefits will not be paid under this policy and attached riders, if any, for any injury, sickness, or nervous or mental disorder:

1. caused by an insurrection, war, declared or undeclared, or acts of war;
2. while an insured is in the active military of any country including any reserve component of the armed services of the United States, including the National Guard, or international organization. Any unearned premium paid for a period not covered because of this exclusion will be returned on a pro-rata basis.
3. caused by normal pregnancy, including childbirth or elective abortion, except when loss results from complications of pregnancy;
4. an insured intentionally inflicts on himself (herself) while sane or insane;
5. caused by an insured's commission of or attempt to commit a felony, or an insured being engaged in an illegal occupation;
6. caused by an insured being intoxicated; or
7. caused by an insured being under the influence of any narcotic, unless administered under the advice of a physician.

**Pre-existing condition limitation**

Benefits will not be paid for a total disability caused by or due to a pre-existing condition unless it begins after an insured has been covered under this policy for 24 months. Pre-existing condition means a sickness, injury, nervous or mental disorder, disease, or physical condition for which medical advice or treatment was recommended by or received from a physician within the 24 months immediately before the effective date of insurance, or for which symptoms of a condition have occurred that would have led a prudent person to seek diagnosis, care, or treatment during the 24 months immediately before the effective date of insurance.

If a condition is listed on the application and is accepted without an exclusion rider, then this condition will be covered and is not subject to the pre-existing condition limitation.

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**Nervous or mental disorders limitation**

If an insured is totally disabled due to nervous or mental disorders, the monthly benefit amount is 50% of the monthly benefit amount for total disability due to injury or sickness, and benefits will be paid for a maximum of 6 months. Benefits will not be paid at the same time for total disability for injury or sickness, and for total disability for nervous or mental disorders. Benefits will begin after satisfaction of the elimination period.

Nervous or mental disorder means any disorder classified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association, or any other such manual endorsed by the American Psychiatric Association.

**Reductions**

The policy contains provisions for Relations of Earnings to Insurance and Insurance with Other Insurers.

**Issue Limitations**

**Issues Ages**

Allowable issue ages are 18-60 age last birthday.

**Allowable Monthly Benefits**

The allowable monthly benefit amounts for the base policy and Social Insurance Substitute Rider combined are \$500 - \$10,000

**Cash with Application**

A cash deposit with the application will not be required.

When a cash deposit is received with the application the following will apply:

1. Only checks or money orders will be accepted.
2. A Conditional Receipt must be signed by the insured and the producer. All of the conditions of the Conditional Receipt will apply.
3. 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
4. On the date that insurance becomes effective, 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.
5. 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 1<sup>st</sup> or 15<sup>th</sup> 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

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of insurance applied for in the application will not become effective under the Conditional Receipt.

6. If all underwriting requirements are not completed within 45 days and received within 60 days of the receipt of the deposit,
  - a. Presidential will close the file and notify the applicant, and producer.
  - b. Presidential will process refund to applicant.
7. If all underwriting requirements are completed within 45 days and received within 60 days,
  - a. Presidential will issue the policy.
  - b. Within 30 days policy acceptance receipt must be received or policy will be closed as "not taken". Presidential will issue a refund check.
  - c. If policy acceptance receipt is received, Presidential will place the policy in force.

**Reductions**

**Insurance with other insurers**

At time of claim, the monthly benefit payable under this policy will be reduced if other valid coverage exists providing benefits for the same loss and of which there was no written notification prior to the start of the disability. The reduced benefit will be proportional to the amount that the monthly benefit payable under this policy and other valid coverage, bears to the total amount of the benefits under all valid coverage for the same period of disability. A portion of the premiums paid will be refunded, in the same proportion as any reduction in benefits.

**Relationship of earnings to insurance**

At time of claim, the monthly benefit payable under this policy will be reduced if the sum of all benefits provided for disability under all valid loss of time coverage, including this policy, exceeds the greater of:

- The insured's monthly earned income at the time disability began; or
- The average of the insured's monthly earned income for the 2 years just prior to start of disability.

The reduced benefit will be proportional to the amount that the insured's monthly earned income or the average of the insured's monthly earned income bears to the total amount of his (her) benefits under all valid loss of time coverage for the same period of disability. This provision will not operate to reduce the total amount of benefits under all valid loss of time coverage below the lesser of \$300 and the sum of all monthly benefits specified under all valid loss of time coverage. A portion of the premiums paid during the prior 2 years will be refunded, in the same proportion as any reduction in benefits.

Valid loss of time coverage as used in this means coverage provided by:

- All loss of time or disability income benefits provided by individual or group policies;
- All employer and association sponsored disability income benefits and salary continuation plans;
- All governmental disability income benefits including state disability income benefits; and Worker's Compensation.

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**Rate Tables**

**Base Policy Level Premium payable to age 65**

Rates are level and based on age last birthday at time of policy issue. Policies will not be back dated to save age. Rates vary by gender, tobacco use, benefit period, elimination period, and 5-year issue age band.

**Non-Tobacco Use**

Annual Premium Rates per \$100 Face Amount – Non-Tobacco:

Benefit Period – 2 Years

Elimination Period – 60 Days

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
18-25	58.00	96.50
26-30	59.00	101.50
31-35	61.50	110.00
36-40	63.50	112.50
41-45	70.00	114.00
46-50	84.00	117.00
51-55	106.50	126.00
56-60	130.00	139.50

Benefit Period – 2 Years

Elimination Period – 90 Days

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
18-25	34.50	54.00
26-30	35.50	55.00
31-35	37.00	59.00
36-40	39.50	61.00
41-45	47.00	63.50
46-50	60.00	73.50
51-55	82.00	85.50
56-60	109.50	98.50

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Benefit Period – 5 Years

Elimination Period – 60 Days

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
18-25	109.00	197.00
26-30	112.00	210.50
31-35	117.00	232.50
36-40	127.00	244.00
41-45	142.00	249.00
46-50	166.00	258.00
51-55	211.00	270.00
56-60	226.50	270.00

Benefit Period – 5 Years

Elimination Period – 90 Days

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
18-25	67.50	107.50
26-30	69.00	110.50
31-35	71.50	121.50
36-40	81.00	128.00
41-45	96.50	136.50
46-50	119.50	154.50
51-55	161.50	175.00
56-60	187.00	185.00

Benefit Period – 5 Years

Elimination Period – 180 Days

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
18-25	56.50	90.50
26-30	59.00	94.00
31-35	63.50	104.50
36-40	72.00	111.00
41-45	86.50	119.50
46-50	107.50	136.00
51-55	146.00	154.50
56-60	173.00	162.00

**Tobacco Use**

Includes smoking cigarettes, pipes and cigars, chewing tobacco, snuff, etc.  
120% of the Non-Tobacco rates

**Policy Fee**

Payable every year \$25  
Non commissionable

**Face Amount:** Monthly benefit payable for disabilities incurred in policy years 3 and later.

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**Social Insurance Substitute Rider**

Annual Premium Rates are per \$100 Rider face amount and equal the base policy rates multiplied by the following factors:

BP	EP60	EP90	EP180
2 yrs	81%	79%	-
5 yrs	71%	69%	66%

**Occupational Extension Benefit Rider**

The Premium for this rider is equal to 10% of sum of premium for base policy and SIS rider, before policy fee.

**Premiums Payable after Age 65**

Premiums at attained ages 65-69 are based on the attained age of the insured. Rates vary by gender, tobacco use, elimination period, and attained age.

Annual Premium Rates, non-tobacco, per \$100 base policy plus Social Insurance Substitute Rider face amount, if any:

Male				Female			
Attained Age	EP60	EP90	EP180	Attained Age	EP60	EP90	EP180
65	179.00	137.50	126.50	65	196.50	113.50	95.00
66	188.50	147.00	136.00	66	206.00	119.00	100.00
67	197.50	156.50	145.50	67	216.50	125.00	105.00
68	206.50	166.50	155.50	68	227.50	130.50	110.00
69	216.00	176.50	165.00	69	238.00	136.50	115.50

Policy Fee: Payable every year \$25  
 Non commissionable

Tobacco Use: 120% of the Non-Tobacco rates

**Modal Factors**

Semi-annual 52.0%  
 Quarterly 26.0%  
 Monthly Auto-Deduct 8.5%

**Substandard**

This is a policy designed to insure substandard risks, therefore, there are no additional substandard rates or requirements. The policy is intended for individuals who are able to perform their daily work duties, yet are unable to qualify for disability coverage in the standard market due to their health history.

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**Reinstatements**

Reinstatement may be allowed if the insured completes a reinstatement application, pays the required premium, and meets the underwriting requirements of this policy. The policy will be reinstated upon the date of underwriting approval or on the 45th day after the date of the application and receipt of the required premium if the insured is not mailed a disapproval of the application. If anyone authorized to receive premiums, accepts the premium without requiring a reinstatement application, this policy is reinstated.

The reinstated policy will only cover:

1. for an injury, one which occurs after the reinstatement date;
2. for a sickness or nervous or mental disorder, one which begins more than 10 days after the reinstatement date.

Any premium accepted in connection with this reinstatement will be applied to a period for which premiums have not been paid, but not to any period more than 60 days prior to the date of reinstatement.

**Policy & Coverage Changes**

No requests for policy or coverage changes that require underwriting review will be considered for the first 2 years the policy is in force. Examples include removal of the tobacco use rating, and removal of Exclusion or Extended Elimination Period riders.

Requests for increases in benefit levels, addition of riders, increase of benefit duration from 2 years to 5 years, and reductions of the elimination period may not be made at any time.

Requests for reductions in benefit levels, removal of riders, decrease of benefit duration from 5 years to 2 years, and increases of the elimination period may be made at any time.

**Underwriting**

**Medical Underwriting**

Applications will be underwritten using attending physician's statements and inspection reports.

Coverage other than applied for may be offered with a policy amendment rider, longer elimination period, shorter benefit period, condition exclusion, or a combination of any of these.

Underwriting decisions to issue coverage are based on a combination of factors. The significance of an impairment to cause disability must be assessed in conjunction with age, occupational risk, avocation, and overall medical status.

This product fills an important need in the individual disability income market in New York. It is designed to provide income protection to those who have been rejected for coverage in the standard individual disability income market due to either medical or non medical factors, but

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who are both able and eager to work full time. Accordingly, every consideration is given to finding a way to offer coverage, even for those suffering from severe conditions. Underwriting judgment is an important aspect of this process.

The medical reports and all supporting information must be considered when making a risk evaluation. Each case is reviewed on an individual basis, as all the variables must be considered. Some conditions listed herein may be considered for coverage. However, the totality of all the variables of the case may lead to a declination.

In the course of underwriting an individual, an unusual condition or circumstance may arise which cannot be anticipated. When such a situation occurs the underwriter will use judgment to modify the terms of acceptance of the risk in a manner consistent with normal underwriting standards and practices.

The severity of the condition and the probability of recurrence will also be taken into consideration in the decision to exclude the condition by rider, extend the elimination period for the condition, or otherwise modify the terms of acceptance of the risk. Unlisted conditions that are similar in nature and anticipated outcomes will also be underwritten in a manner consistent with listed conditions.

**Pre-Screening Prospects**

We encourage producers to pre screen their applications and offer the following options:

1. If the prospect has recently been declined by another carrier, you may mail or fax us a copy of the declined application.
2. Complete the pre screening questionnaire and mail or fax it to us. The questionnaire is available on our website <http://NY.impairedrisks.com>.
3. Call us with the information requested in the pre screening questionnaire.
4. If you have available recent medical records that you would like to submit for consideration, mail them to us together with a signed HIPAA authorization. Please do not fax.

Regardless of how the information is submitted to us, we will usually be able to give you a preliminary decision within 48 hours. If you submit complete medical records, then we will respond as quickly as possible, generally, within 7 business days.

The information on which the preliminary decision is based must be consistent with the completed application and all other underwriting requirements. All decisions will be subject to receipt of the completed application and all other underwriting requirements.

**Financial Underwriting**

Only individuals actively at work for at least 30 hours per week for the last 12 months earning \$40,000 or more per year are eligible for the 2 year plan. Only individuals actively at work for at

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least 30 hours per week for the last 12 months earning \$60,000 or more per year are eligible for the 5 year plan.

**Financial Documentation**

Financial documentation requirements differ depending upon the business activity of the proposed insured.

- Only income from *active* sources, not *passive* sources as per IRS Guidelines, will be considered.
- Any income from investment activities in stocks, bonds, etc. will not be considered.
- Net income earned from a business will be considered after deducting all expenses incurred by the business.
- Any salary paid by a sole proprietor to himself/herself is acceptable, along with net income earned by the business owner applicant.
- As a general rule, contributions to pension or 401k plans on a pre-tax basis for self employed persons, will be included in the earned income calculation.

*W-2s, Tax Returns*

- A copy of the last 2 years' W-2s, if the applicant is an employee of a business entity.
- Also acceptable is a Form 1040 tax return, as long as income earned can be verified and allocated to the applicant.
- A current paycheck stub reflecting at least 3 months of year-to-date earnings may also be an acceptable form of income documentation.
- In order for annual bonuses to be considered as earned income, proof of past years' payments and a letter from the employer identifying the continued likelihood of the bonus payments in current and future years are required.

*Home Business*

- An accurate and complete description of the business, including all duties.
- Copies of any contractual arrangements with clients, and/or letters from employers describing the work-at-home arrangement.
- A minimum of one, preferably two years, of Tax Returns in the same business.

*Financial Requirements Chart*

	<b>Employees</b>	<b>Sole Proprietor</b>	<b>Partnership</b>	<b>S-Corp</b>	<b>C-Corp</b>
<b>Forms Required</b>	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
<b>Definition of Earned Income</b>	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.

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**Occupational Classes**

There are no occupational classes.

**Non-Eligible Occupations**

A list of non-eligible occupations follows:

Car washers	Racing drivers
Domestics	Rodeo riders
Explosive handlers	Seasonal workers
Fireworks manufacturing	Steeple jacks
Furnace personnel	Street vendors
High window cleaners	Structural iron riggers
Judo & Karate instructors	Taverns (non-management personnel)
Kitchen help	Test pilots
Migratory workers	Tree toppers
Oil & natural gas workers	Tower erectors
Powerline splicers	Underground coal miners

**Replacement Ratios**

Generally, the monthly benefit that may be issued under the policy and the Social Insurance Substitute Rider combined will be limited to 60% of income, or \$10,000, whichever is less. The minimum combined monthly benefit is \$500, of which at least \$200 must be base policy benefits.

Amounts available are limited based on income in \$10 increments in accordance with the following schedule, if no other insurance is in effect. If other insurance is in effect, then the amounts below will be reduced by the other insurance.

<b>Monthly Salary</b>	<b>Base Policy</b>	<b>Social Insurance Substitute Rider</b>
3,333	1,570	600
3,500	1,590	650
3,600	1,640	660
3,700	1,710	660
3,800	1,760	670
3,900	1,830	670
4,000	1,840	680
4,100	1,890	690
4,200	1,940	710
4,300	1,990	720
4,400	2,030	740
4,500	2,090	750
4,600	2,130	770
4,700	2,170	790
4,800	2,210	810

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<b>Monthly Salary</b>	<b>Base Policy</b>	<b>Social Insurance Substitute Rider</b>
4,900	2,260	830
5,000	2,250	850
5,100	2,290	870
5,200	2,340	880
5,300	2,390	900
5,400	2,440	910
5,500	2,480	930
5,600	2,530	940
5,700	2,570	960
5,800	2,630	970
5,900	2,670	990
6,000	2,660	1,000
6,200	2,780	1,000
6,400	2,900	1,000
6,600	3,030	1,000
6,800	3,150	1,000
7,000	3,200	1,000
7,200	3,320	1,000
7,400	3,440	1,000
7,600	3,560	1,000
7,800	3,680	1,000
8,000	3,800	1,000
8,200	3,920	1,000
8,400	4,040	1,000
8,600	4,160	1,000
8,800	4,280	1,000
9,000	4,400	1,000
9,200	4,520	1,000
9,400	4,640	1,000
9,600	4,760	1,000
9,800	4,880	1,000
10,000	5,000	1,000
10,200	5,120	1,000
10,400	5,240	1,000
10,600	5,360	1,000
10,800	5,480	1,000
11,000	5,600	1,000
11,200	5,720	1,000
11,400	5,840	1,000
11,600	5,960	1,000
11,800	6,080	1,000
12,000	6,200	1,000
12,200	6,320	1,000

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<b>Monthly Salary</b>	<b>Base Policy</b>	<b>Social Insurance Substitute Rider</b>
12,400	6,440	1,000
12,600	6,560	1,000
12,800	6,680	1,000
13,000	6,800	1,000
13,200	6,920	1,000
13,400	7,040	1,000
13,600	7,160	1,000
13,800	7,280	1,000
14,000	7,400	1,000
14,200	7,520	1,000
14,400	7,640	1,000
14,600	7,760	1,000
14,800	7,880	1,000
15,000	8,000	1,000
15,200	8,120	1,000
15,400	8,240	1,000
15,600	8,360	1,000
15,800	8,480	1,000
16,000	8,600	1,000
16,200	8,720	1,000
16,400	8,840	1,000
16,600	8,960	1,000
16,800	9,000	1,000

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**Build Ratings – Height and Weight**

<b>MALES</b>			<b>FEMALES</b>		
<b>Height Ft.</b>	<b>In.</b>	<b>Maximum Weight*</b>	<b>Height Ft.</b>	<b>In.</b>	<b>Maximum Weight*</b>
5	0	<b>326</b>	4	8	<b>304</b>
5	1	<b>330</b>	4	9	<b>308</b>
5	2	<b>335</b>	4	10	<b>312</b>
5	3	<b>340</b>	4	11	<b>316</b>
5	4	<b>345</b>	5	0	<b>321</b>
5	5	<b>351</b>	5	1	<b>326</b>
5	6	<b>358</b>	5	2	<b>331</b>
5	7	<b>365</b>	5	3	<b>336</b>
5	8	<b>372</b>	5	4	<b>342</b>
5	9	<b>379</b>	5	5	<b>347</b>
5	10	<b>386</b>	5	6	<b>353</b>
5	11	<b>393</b>	5	7	<b>359</b>
6	0	<b>400</b>	5	8	<b>365</b>
6	1	<b>407</b>	5	9	<b>372</b>
6	2	<b>415</b>	5	10	<b>379</b>
6	3	<b>423</b>	5	11	<b>387</b>
6	4	<b>431</b>	6	0	<b>396</b>
6	5	<b>439</b>	6	1	<b>405</b>
6	6	<b>448</b>	6	2	<b>414</b>
6	7	<b>457</b>	6	3	<b>423</b>
6	8	<b>465</b>	6	4	<b>432</b>

- Insurable weights over the Maximums are subject to individual consideration by the underwriter, including consideration of other medical and/or non-medical factors.
- This information applies to proposed insureds without any other medical and/or non-medical factors.

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**Tumors**

Tumors are classified into classes determined by location and stage. Date of recovery and type of treatment are also considered when evaluating the risk. Date of recovery means date of removal and/or date of last treatment with radiotherapy or chemotherapy.

**Class 1**

These tumors may be large in size, invasive into surrounding tissues, high grade and high stage tumors that consist of anaplastic or undifferentiated cell types with local lymph node involvement as well as distant metastatic sites or history of recurrence. The overall prognosis for long term survival is poor.

Present	NO
History of, complete recovery, no recurrence, no metastasis	
Under 2 years	NO
After 2 years	MAY BE ACCEPTABLE

**Class 2**

These tumors may be large in size, locally invasive, of high grade and stage, consisting of poorly differentiated to undifferentiated cell types with local lymph node involvement. However, there is no evidence of distant metastatic sites and no history of tumor recurrence. The prognosis is guarded to poor for long term survival.

Present	NO
History of, complete recovery, no recurrence, no metastasis	
Under 2 years	NO
After 2 years	MAY BE ACCEPTABLE

**Class 3**

These tumors may be moderate to large in size, of moderate grade and stage with moderately to poorly differentiated cell types. They may be locally invasive into surrounding tissues with no evidence of lymph node involvement; no distant metastatic sites; no history of recurrence.

Present	NO
History of, complete recovery, no recurrence, no metastasis	
Under 2 years	NO
After 2 years	MAY BE ACCEPTABLE

**Class 4**

These tumors may be small to moderate in size of intermediate grade and stage with well differentiated to moderately differentiated cell types. There is no to minimal local extension into

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surrounding tissues. Local lymph nodes are negative; there is no evidence of distant metastasis or history of recurrence. The prognosis for long term survival is fair.

Present	NO
History of, complete recovery, no recurrence, no metastasis Under 2 years After 2 years	NO MAY BE ACCEPTABLE

**Class 5**

These tumors may be small to moderate in size and of a low tumor grade and stage with well differentiated cell types. There is no local extension or invasion into surrounding tissues. Local lymph nodes are negative with no evidence of distant metastasis and no history of tumor recurrence. The prognosis for long term survival is very good.

Present	NO
History of, complete recovery, no recurrence, no metastasis Under 1 year After 1 year	NO MAY BE ACCEPTABLE

**Class 6**

These are well-differentiated tumors with minimal to no malignancy potential. Cell types are well differentiated with little or no Tendency towards local extension or invasion; negative local lymph nodes; no potential for distant metastasis. The prognosis for long term survival is very good to excellent.

MAY BE ACCEPTABLE

**Class 7**

These are benign tumors with no malignant potential. They are slow growing and usually do not invade adjacent tissues and do not metastasize. Cell types are well differentiated. They are amenable in most instances to surgical excision and cure. There is usually no impact on long term survival.

MAY BE ACCEPTABLE

**Class 8**

Special Tumors that cannot be classified into only 1 of the above categories.

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**Health Conditions**

Where duration is indicated, herein, it refers to the time since recovery, or time since diagnosis, treatment and under appropriate medical treatment and/or medical follow up unless otherwise indicated.

<b>CONDITION</b>	<b>MAY BE ACCEPTABLE</b>
<b>A.L.S. (LOU GEHRIG'S DISEASE)</b>	NO
<b>ABSCESSES</b>	YES
<b>ACHALASIA</b>	YES
<b>ACNE</b>	YES
<b>ACROMEGALY</b>	YES
<b>ADD / ADHD</b>	YES
<b>ADDISON'S DISEASE</b>	YES
<b>ADHESIONS</b>	YES
<b>ADJUSTMENT DISORDER</b>	YES
<b>AFFECTIVE DISORDERS</b>	YES
<b>AIDS / ARC / HIV POSITIVE</b>	NO
<b>ALCOHOL ABUSE</b>	YES (AFTER 1 YEAR)
<b>ALCOHOLISM</b>	YES (AFTER 1 YEAR)
<b>ALZHEIMER'S DISEASE</b>	NO
<b>AMPUTATIONS</b>	YES
<b>ANEMIA</b>	YES
<b>ANEURYSM (OPERATED / REPAIRED)</b>	YES (AFTER 1 YEAR)
<b>ANGINA / ANGINA PECTORIS</b>	YES (AFTER 1 YEAR)
<b>ANGIOPLASTY / BYPASS SURGERY</b>	YES (AFTER 1 YEAR)
<b>ANKYLOSING SPONDYLITIS</b>	YES
<b>ANOREXIA NERVOSA</b>	YES
<b>ANXIETY</b>	YES
<b>AORTIC STENOSIS (CONGENITAL)</b>	YES
<b>ARRHYTHMIAS</b>	YES
<b>ARTERIOSCLEROSIS</b>	YES
<b>ARTHRITIS</b>	YES
<b>ASTHMA</b>	YES
<b>ATHEROSCLEROSIS</b>	YES (AFTER 1 YEAR)
<b>ATRIAL FIBRILLATION - CHRONIC</b>	YES (AFTER 1 YEAR)
<b>ATRIAL SEPTAL DEFECTS</b>	YES
<b>ATTEMPTED SUICIDE</b>	YES (AFTER 1 YEAR)
<b>AUTISM</b>	NO
<b>BACTERIAL ENDOCARDITIS</b>	YES
<b>BEHCET'S SYNDROME</b>	YES
<b>BELL'S PALSY</b>	YES
<b>BERGER'S DISEASE</b>	YES
<b>BICUSPID AORTIC VALVE</b>	YES

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<b>BI-POLAR DISORDERS</b>	YES
<b>BLINDNESS</b>	YES
<b>BRAIN ANEURYSM / SYNDROMES</b>	YES (AFTER 1 YEAR)
<b>BRONCHITIS</b>	YES
<b>BUILD</b>	See the Build Ratings Table
<b>BULIMIA</b>	YES
<b>BUNDLE BRANCH BLOCK – LEFT</b>	YES (AFTER 1 YEAR)
<b>BUNDLE BRANCH BLOCK - RIGHT</b>	YES
<b>CANCER</b>	See the Tumors Table
<b>CARDIOMEGALY</b>	YES
<b>CARDIO-RENAL DISEASE</b>	YES
<b>CATARACT</b>	YES
<b>CEREBRAL PALSY</b>	YES
<b>CHOLESTEROL – HIGH LEVELS</b>	YES
<b>CHRONIC FATIGUE SYNDROME</b>	YES
<b>CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)</b>	YES (AFTER 2 YEARS)
<b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)</b>	YES
<b>CIRRHOSIS</b>	NO
<b>COARCTATION OF THE AORTA</b>	YES
<b>COLITIS</b>	YES
<b>CONCUSSION</b>	YES
<b>CONVULSIONS</b>	YES
<b>COR PULMONALE</b>	YES (AFTER 1 YEAR)
<b>CORONARY ARTERY BYPASS GRAFT (CABG) OR PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA)</b>	YES (AFTER 1 YEAR)
<b>CORONARY ARTERY DISEASE (CAD)</b>	YES (AFTER 1 YEAR)
<b>CORONARY OCCLUSIONS</b>	YES (AFTER 1 YEAR)
<b>CROHN'S DISEASE</b>	YES
<b>CUSHING'S SYNDROME / DISEASE - MALIGNANT TUMOR EXCISED OR RADIATED</b>	YES (2 YRS AFTER TREATMENT COMPLETED)
<b>CVA / STROKE</b>	YES (AFTER 1 YEAR)
<b>CYSTIC FIBROSIS</b>	NO
<b>CYSTS</b>	YES
<b>D.U.I. (DRIVING UNDER THE INFLUENCE)</b>	YES (AFTER 1 YEAR)
<b>DEAFNESS</b>	YES
<b>DEFIBRILLATOR IMPLANT</b>	YES (AFTER 1 YEAR)
<b>DEFORMITY</b>	YES
<b>DEPRESSION</b>	YES
<b>DIABETES</b>	YES
<b>DIVERTICULA / DIVERTICULITIS</b>	YES
<b>DOWN'S SYNDROME</b>	NO
<b>DRUG ABUSE</b>	YES (AFTER 1 YEAR)

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<b>CONDITION</b>	<b>MAY BE ACCEPTABLE</b>
<b>DUODENAL ULCER</b>	YES
<b>DUPUYTREN'S CONTRACTURE</b>	YES
<b>DWARFISM</b>	YES
<b>EDEMA</b>	YES
<b>EMPHYSEMA</b>	YES
<b>EMPYEMA</b>	YES
<b>ENCEPHALITIS</b>	YES
<b>ENDOCARDITIS, BACTERIAL</b>	YES
<b>EPILEPSY</b>	YES
<b>ESOPHAGEAL IMPAIRMENTS</b>	YES
<b>EYE DISORDER</b>	YES
<b>FIBROMYALGIA</b>	YES
<b>FISTULA</b>	YES
<b>FRACTURE</b>	YES
<b>GALL BLADDER DISORDER</b>	YES
<b>GANGLION</b>	YES
<b>GASTRITIS</b>	YES
<b>GASTROINTESTINAL POLYPS</b>	YES
<b>GENERALIZED ANXIETY DISORDER</b>	YES
<b>GENITOURINARY DISORDER</b>	YES
<b>GLAUCOMA</b>	YES
<b>GLOMERULONEPHRITIS</b>	YES
<b>GLYCOSURIA</b>	YES
<b>GOUT</b>	YES
<b>H.I.V. POSITIVE</b>	NO
<b>HEARING IMPAIRMENT</b>	YES
<b>HEART ATTACK</b>	YES (AFTER 1 YEAR)
<b>HEART MURMURS</b>	YES
<b>HEART VALVE REPLACEMENTS</b>	YES (AFTER 1 YEAR)
<b>HEMATEMESIS</b>	YES
<b>HEMATURIA</b>	YES
<b>HEMOCHROMATOSIS</b>	YES
<b>HEMOPHILIA</b>	YES
<b>HEPATITIS</b>	YES
<b>HERNIA</b>	YES
<b>HIGH BLOOD PRESSURE</b>	YES
<b>HIGH CHOLESTEROL</b>	YES
<b>HODGKIN'S DISEASE</b>	YES (AFTER 2 YEARS)
<b>HUNTINGTON'S CHOREA / DISEASE</b>	AGE 0-44 = NO AGE 45 + = POSSIBLE CONSIDERATION
<b>HYPERTENSION / HIGH BLOOD PRESSURE</b>	YES
<b>HYPOGLYCEMIA</b>	YES
<b>ILEITIS</b>	YES

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<b>INTERVERTEBRAL DISC DISEASE</b>	YES
<b>INTESTINAL BYPASS</b>	YES (AFTER 1 YEAR)
<b>KIDNEY STONES</b>	YES
<b>KYPHOSIS</b>	YES
<b>LEFT BUNDLE BRANCH BLOCK</b>	YES (AFTER 1 YEAR)
<b>LEUKEMIA</b>	YES (2 YRS AFTER TREATMENT COMPLETED)
<b>LEUKOCYTOSIS</b>	YES
<b>LIVER ABSCESS</b>	YES
<b>LIVER ENZYMES - ELEVATED</b>	YES
<b>LORDOSIS</b>	YES
<b>LOW BLOOD PRESSURE</b>	YES
<b>LUNG ABSCESS</b>	YES
<b>LUPUS- DISCOID OR SYSTEMIC</b>	YES
<b>LYME DISEASE</b>	YES
<b>MACULAR DEGENERATION</b>	YES
<b>MANIC-DEPRESSIVE DISORDER</b>	YES
<b>MELANOMA</b>	See the Tumors Table
<b>MENIERE'S DISEASE</b>	YES
<b>MENINGITIS</b>	YES
<b>MENTAL / NERVOUS DISORDERS</b>	YES
<b>MITRAL VALVE PROLAPSE</b>	YES
<b>MULTIPLE SCLEROSIS</b>	YES (AFTER 5 YEARS WITHOUT SYMPTOMS)
<b>MUSCULAR DYSTROPHY</b>	YES
<b>MUSCULO-SKELETAL SYSTEM DISORDERS NOT SPECIFICALLY LISTED</b>	YES
<b>MYASTHENIA GRAVIS</b>	YES
<b>MYOCARDITIS</b>	YES
<b>NARCOLEPSY</b>	YES
<b>NEPHRECTOMY</b>	YES
<b>NEPHRITIS</b>	YES
<b>NERVOUS DISORDERS</b>	YES
<b>NERVOUS SYSTEM DISORDERS NOT SPECIFICALLY LISTED</b>	YES
<b>NEURITIS</b>	YES
<b>NEUROPATHY</b>	YES
<b>OBSESSIVE COMPULSIVE DISORDER</b>	YES
<b>ORGAN TRANSPLANT RECIPIENT</b>	NO
<b>OSTEITIS DEFORMANS</b>	YES
<b>OSTEOARTHRITIS</b>	YES
<b>OSTEOMALACIA</b>	YES
<b>OSTEOMYELITIS</b>	YES
<b>OVERWEIGHT / OBESITY</b>	See the Build Ratings Table

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<b>CONDITION</b>	<b>MAY BE ACCEPTABLE</b>
<b>PACEMAKER IMPLANT</b>	YES (AFTER 1 YEAR)
<b>PAGET'S DISEASE OF BONE</b>	YES
<b>PANCREATIC IMPAIRMENTS</b>	YES
<b>PANCREATITIS</b>	YES
<b>PANIC DISORDER</b>	YES
<b>PARALYSIS</b>	YES
<b>PARAPLEGIC</b>	YES
<b>PARKINSON'S DISEASE</b>	YES
<b>PAROXYSMAL ATRIAL TACHYCARDIA</b>	YES
<b>PECTUS EXCAVATUM</b>	YES
<b>PEPTIC ULCER</b>	YES
<b>PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA)</b>	YES (AFTER 1 YEAR)
<b>PERIPHERAL VASCULAR DISORDERS / DISEASES</b>	YES
<b>PERSONALITY DISORDER</b>	YES
<b>PHLEBITIS</b>	YES
<b>PLEURISY</b>	YES
<b>POLIOMYELITIS / POST POLIO SYNDROME</b>	YES
<b>POLYCYSTIC KIDNEY DISEASE</b>	YES
<b>POLYCYTHEMIA VERA</b>	YES
<b>POLYNEURITIS</b>	YES
<b>POLYPS</b>	YES
<b>PROSTATITIS</b>	YES
<b>PSORIASIS</b>	YES
<b>PSORIATIC ARTHRITIS</b>	YES
<b>PURPURA</b>	YES
<b>PYELITIS / PYELONEPHRITIS</b>	YES
<b>RAYNAUD'S DISEASE / SYNDROME</b>	YES
<b>REGIONAL ILEITIS</b>	YES
<b>REITER'S DISEASE / SYNDROME</b>	YES
<b>RESPIRATORY SYSTEM DISORDERS NOT SPECIFICALLY LISTED</b>	YES
<b>RETINITIS PIGMENTOSA</b>	YES
<b>RHEUMATIC HEART DISORDER</b>	YES
<b>RHEUMATOID ARTHRITIS</b>	YES
<b>RIGHT BUNDLE BRANCH BLOCK</b>	YES
<b>SARCOIDOSIS</b>	YES
<b>SCLERODERMA</b>	YES
<b>SCOLIOSIS</b>	YES
<b>SINUS TACHYCARDIA</b>	YES
<b>SINUSITIS</b>	YES
<b>SLEEP APNEA</b>	YES
<b>SPINAL DEFORMITY (SCOLIOSIS, LORDOSIS, &amp; KYPHOSIS)</b>	YES

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<b>CONDITION</b>	<b>MAY BE ACCEPTABLE</b>
<b>SPLEEN IMPAIRMENTS</b>	YES
<b>SPONDYLITIS, ANKYLOSING</b>	YES
<b>STRESS</b>	YES
<b>STROKE</b>	YES (AFTER 1 YEAR)
<b>SUICIDE ATTEMPT / IDEATION</b>	YES (AFTER 1 YEAR)
<b>SYNCOPE</b>	YES
<b>THROMBOCYTOPENIA</b>	YES
<b>THROMBOSIS</b>	YES
<b>TOURETTE'S SYNDROME</b>	YES
<b>TRANSIENT ISCHEMIC ATTACK (T.I.A.)</b>	YES (AFTER 1 YEAR)
<b>TRANSPLANT RECIPIENTS – ORGAN</b>	NO
<b>TRANSSEXUAL</b>	NO
<b>TRANSURETHRAL RESECTION</b>	YES
<b>TRANSVERSE MYELITIS</b>	YES
<b>TUBERCULOSIS</b>	YES
<b>TUMORS (MALIGNANT)</b>	See the Tumors Table
<b>ULCERATIVE COLITIS</b>	YES
<b>ULCERS</b>	YES
<b>UNDERWEIGHT</b>	YES
<b>UREMIA</b>	NO
<b>URINARY STONE</b>	YES
<b>VARICOCELE / HYDROCELE</b>	YES
<b>VARICOSE VEINS</b>	YES
<b>VENOUS THROMBOSIS / PHLEBITIS</b>	YES
<b>VENTRICULAR SEPTAL DEFECTS</b>	YES
<b>VERTIGO</b>	YES
<b>VISION IMPAIRMENT</b>	YES
<b>VON WILLEBRAND'S DISEASE</b>	YES
<b>WILSON'S DISEASE</b>	YES
<b>WOLFF-PARKINSON-WHITE SYNDROME</b>	YES

**Criminal Records**

Generally disability insurance coverage should not be issued to individuals involved in criminal activity. Favorable cases are those who were involved in the distant past. If it can now be determined that the individual has been responsible for several years and stable we can consider coverage.

<b>OFF PAROLE AND OFF PROBATION</b>	<b>MAY BE ACCEPTABLE</b>
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**Risk Insurance and Reinsurance Solutions, Inc.**  
**Presidential Life Insurance Company**  
**Income Guard**  
**A Graded Benefit Impaired Risk Disability Income Product**  
**Field Manual**

**Application**

Following is a complete application, including all required forms. The application may be downloaded from our website <http://NY.impairedrisks.com>.

**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:**

	<b>Employees</b>	<b>Sole Proprietor</b>	<b>Partnership</b>	<b>S-Corp</b>	<b>C-Corp</b>
<b>Forms Required</b>	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
<b>Definition of Earned Income</b>	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**

Risk Insurance and Reinsurance Solutions, Inc.  
Attn: Underwriting  
1208 W. Newport Center Dr., Suite 202  
Deerfield Beach, FL 33442  
(866) 747-5677 or (954) 420-4400

**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**

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

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

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

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

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**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.

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

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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

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

**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 1<sup>st</sup> 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  
NYACK, NEW YORK**

**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:

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To the following person, whose name and address is:

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To me directly. My name and address is:

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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

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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**

**⓪⓪⓪ PLEASE VERIFY ALL ACCOUNT INFORMATION WITH YOUR BANK ⓪⓪⓪**

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

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