

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case Number _____

Proposed Insured: _____ <small>(First) (Middle) (Last)</small>			Telephone interview done (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> am <input type="checkbox"/> pm	
Address: (No. & Street) _____			Phone _____ Best time to call _____	
City: _____		State: _____	Zip Code: _____	
			E-mail Address _____ @ _____	

<input type="checkbox"/> Male <input type="checkbox"/> Female	Sex	Date of Birth Mo. Day Yr / /	Age	State of Birth	SS# _____	Height: _____ ft _____ in	Occupation: _____
					DL# _____		
					SOI: _____		

Owner: Name _____	SS# _____	Address: _____
Payor: Name _____	SS# _____	Address: _____

Primary Beneficiary _____	SS# _____	Relationship _____
Contingent Beneficiary _____	SS# _____	Relationship _____

Plan: _____ <input type="checkbox"/> Return of Premium (not available on 10 year term plan)	Face Amount
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

Riders: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> CIA _____ Units <input type="checkbox"/> Disability Income \$ _____ <input type="checkbox"/> Critical Illness % _____ <input type="checkbox"/> Other _____	Policy Date Request: ____ / ____ / ____ Mail Policy: <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner
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Mode: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Qtrly <input type="checkbox"/> Other _____ Modal Prem \$ _____	CWA: <input type="checkbox"/> E-Check Immediate 1st Prem <input type="checkbox"/> Collected \$ _____
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Do you have any existing life or disability insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	Company _____
Will you replace or change any existing life or disability insurance or annuity? .. <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy # _____ Amount of Coverage \$ _____

Other Proposed Insureds: Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

SECTION A: Answer Questions 1, 2, and 3 for all Proposed Insureds.

- Has any Proposed Insured been diagnosed, treated or been prescribed medication by a medical professional or currently under treatment for (circle condition that applies):
 - high blood pressure, heart attack, angina, arrhythmia, aneurysm, stroke, TIA, heart or circulatory disease or disorder? Yes No
 - diabetes, pancreas disorder, hepatitis, Crohn's Disease, ulcerative colitis, liver or digestive disease or disorder? Yes No
 - cancer in any form, lung disease or disorder, seizures, mental or nervous disorder, bipolar disorder, paralysis, blindness? Yes No
 - any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? Yes No
 - connective tissue disease, systemic lupus (SLE), anemia, arthritis, or any disorder of the back, joints, muscles? Yes No
 - any other disease or disorder, injury, surgery **within the past 24 months**? Yes No
- Within the past 2 years** has any proposed insured participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving or made any flights as a pilot, student pilot, or crew member of any aircraft? Yes No
- Has any Proposed Insured:
 - been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
 - within the past 5 years**, pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked or **within the past 6 months**, been on probation or parole? Yes No
 - within the past 5 years**, used illegal drugs, or abused alcohol or drugs, or had or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? Yes No
 - within the past 6 months**, been prohibited from actively working full time (30 hours or more per week) at their regular occupation due to any illness, injury, or health related problem, or are you **currently** disabled? Yes No
 - within the past 12 months**, consulted a physician, had surgery, been hospitalized, or had diagnostic tests (excluding AIDS/HIV tests) such as EKG, X-ray, MRI, CAT scan? Yes No
 - within the past 12 months**, had diagnostic testing (excluding AIDS/HIV tests), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? Yes No

SECTION B: If applying for Critical Illness Rider answer Question 4. (Provide: name, relationship, age at onset, medical condition.)

- Has any Proposed Insured had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant or been diagnosed with heart disease, cerebrovascular disease, or internal cancer prior to age 60? Yes No

SECTION C: Give details to all "Yes" answers in Section A and B and list current medications (use COMMENTS section on back for additional space).

Illness, Injury, Disease, or Condition	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		