7. PRODUCT DETAILS

Product Name

Coverage Amount (This is the amount of life insurance coverage you are applying for.)
$

Rate Class Applied for:

☐ Preferred Non-Tobacco ☐ Preferred Tobacco ☐ Preferred Juvenile
☐ Standard Non-Tobacco ☐ Standard Tobacco ☐ Standard Juvenile ☐ Graded

If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ **Yes** ☐ **No**
if Yes →

Adjust face amount to premium? ☐ **Yes** ☐ **No**

Automatic Premium Loan (may not be available on all policies). ☐ Elect ☐ Do Not Elect

ADDITIONAL BENEFITS (Not available with all products and not available in all States)

Benefit	Amount
☐ Accidental Death Benefit Rider	Coverage amount equal to policy face amount
☐ Child/Grandchild Rider (Complete the Child/Grandchild Rider Supplement Application)	**$**

8. PAYMENT OPTIONS

Please select a payment option and complete the Payment Authorization form.

Payment Option ☐ Automatic Bank Draft ☐ Social Security Billing ☐ Credit Card ☐ Check

9. LIFESTYLE

A. Within the last 12 months have you used nicotine replacement, smoking or tobacco products in any form including, but not limited to the following: nicotine gum, patch or pills; cigarettes; cigars; pipe; chew; snuff; e-cigarettes; vape; hookah; or have you used marijuana more than 12 times in the last 12 months? ☐ **Yes** ☐ **No**

B. Height (feet and inches)

C. Current Weight (pounds)

10. MEDICAL HISTORY PART 1

Yes No

Have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

A. Currently under the age of 18 with autism, depression, bipolar disorder or schizophrenia? ..... ☐ ☐

B. Prior to the age of 45 with Heart Failure or Congestive Heart Failure? ..... ☐ ☐

C. Are you currently hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care; or been advised or planning to have surgery requiring general anesthesia? ..... ☐ ☐

Home Health Care is defined as: Medical care provided by a medical professional, friends or family member including, but not limited to arranging medications, taking blood pressure or sugar readings, administering medications, wound care, feeding tube, etc.

D. Have you ever been diagnosed by a member of the medical profession or tested positive for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or tested positive on an AIDS/HIV-related test? ..... ☐ ☐

E. Have you ever been the recipient or been given medical advice by a member of the medical profession to be a recipient of stem-cell, tissue, bone marrow, or organ transplant (other than corneal)? ..... ☐ ☐

Have you ever been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

F. Alzheimer's, dementia, memory loss, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, pulmonary fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months? ..... ☐ ☐

Continued on next page.

10. MEDICAL HISTORY PART 1 (Continued)

	Yes	No
G. Diabetic coma?	☐	☐
H. Amputation other than at the time of an accident or trauma?	☐	☐
I. Metastatic cancer, recurrent cancer, multiple cancers or cancer with lymph node involvement?	☐	☐

During the last 2 years have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

J. Cancer (other than basal cell carcinoma)?	☐	☐

During the last 2 years have you:

K. Had testing by a medical professional for which the results have not been received, been non-compliant with physician orders regarding treatment plans, or been advised to have any diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been done?	☐	☐
L. Attempted suicide; been incarcerated, on probation, on parole, or convicted of or awaiting trial for a felony?	☐	☐
M. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?	☐	☐

If all questions in Part 1 are answered "No," proceed to Part 2.
If any question in Part 1 is answered "Yes", you are not eligible for any coverage.

11. MEDICAL HISTORY PART 2

	Yes	No
Have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:		
A. Prior to the age of 20 with Diabetes (other than gestational diabetes)?	☐	☐
B. Prior to the age of 26 with Crohn's Disease?	☐	☐
C. Prior to the age of 45 with Parkinson's Disease; Coronary Artery Disease, Peripheral Vascular Disease, or Cerebral Vascular Disease; Heart Attack, Transient Ischemic Attack (TIA), or Stroke; Cardiac Surgery, Bypass Surgery, Stent Implant, Angioplasty, Pacemaker or Defibrillator Implant, or Heart Valve Replacement?	☐	☐

	Yes	No
Have you ever been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:		
D. Cirrhosis, heart failure, or congestive heart failure (CHF); or an aneurysm that has not been surgically corrected (still present)?	☐	☐
E. Hepatitis C? (If yes, proceed to E1 & E2.)	☐	☐

E1. Has the Hepatitis C been cured?

☐ Cured ☐ Not Cured

E2. If cured, when was the last blood test (RNA PCR Titer) showing the Hepatitis C was cured?

☐ 0-24 months after treatment ended ☐ More than 24 months after treatment ended

If the answer to E2 is 0-24 months, then the best rate class is Graded. If the answer is more than 24 months, then the best rate class is Standard and the answer counts as a "No" when referring to directions below.

	Yes	No
F. During the last 4 years have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than basal cell carcinoma)?	☐	☐
G. During the last 2 years have you used illegal drugs or been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs), muscular dystrophy, or systemic lupus erythematosus (SLE)?	☐	☐

If SLE has been in remission and there has been no treatment for more than two years, you may then answer this question "No" in regard to only the SLE.

	Yes	No
During the last 2 years have you:		
H. Required assistance with activities of daily living (ADL's) such as bathing, dressing, eating, toileting, getting in and out of chair or bed, or do you have ongoing neurological incontinence or, has a medical professional recommended that you be confined to a Nursing Home?	☐	☐

If "Yes", you are not eligible for the Nursing Home Option on the Accelerated Death Benefit Rider.

Continued on next page.

11. MEDICAL HISTORY PART 2 (Continued)

I. Used a wheelchair, electric scooter or electric cart? ☐ **Yes** ☐ **No**

if Yes →

I1. If yes, provide details regarding use:

- ☐ Currently use or use occasionally at facilities such as, but not limited to, the grocery store, department stores, warehouse stores, airports
- ☐ Reason for use is expected to resolve in the next 3 months or the reason for use has resolved

If the answer to I1 is "Reason for use...", count I as a "No" when referring to directions below.

During the last 1 year have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:	**Yes**	**No**
J. More than 6 seizures; or been diagnosed with, been treated for or advised to receive treatment for any liver disease (including but not limited to autoimmune hepatitis) other than cirrhosis or Hepatitis C that should have been noted in a prior question?	☐	☐
K. Heart attack, stroke (CVA) or transient ischemic attack (TIA)?	☐	☐
L. Used oxygen to assist in breathing (including for Sleep Apnea); received kidney dialysis; kidney failure or chronic kidney disease (stage 4 or 5); encephalitis; or have you been unemployed or disabled and been diagnosed with, treated for or been given medical advice by a member of the medical profession for chronic pain?	☐	☐

Chronic Pain is defined as: *Pain lasting more than 6 months or requiring 6 or more fills of narcotic pain prescriptions in any 12 month period.*

M. Angina (chest pain); or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or had an aneurysm surgically corrected? ☐ **Yes** ☐ **No**

if Yes, to Angina →

M1. When was the angina (chest pain) first diagnosed?

- ☐ 0-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 24 months ago

If the answer to M1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count M as a "No" when referring to directions below.

If all questions in Part 2 are answered "No," proceed to Part 3.
If one question in Part 2 is answered "Yes," you are potentially eligible for the Graded Death Benefit product.
If two or more questions in Part 2 are answered "Yes," you are not eligible for any coverage.

12. MEDICAL HISTORY PART 3

	Yes	**No**
A. Prior to the age of 45, have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than Basal Cell)?	☐	☐

Have you ever been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

B. Bipolar disorder or schizophrenia?	☐	☐
C. Parkinson's disease, multiple sclerosis, systemic lupus erythematosus (SLE), sarcoidosis, Crohn's disease, ulcerative colitis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?	☐	☐

Chronic Asthma is defined as: *Using inhalers year round on a daily or weekly basis, or filling prescriptions 6 or more times in any 12 month period.*

During the last 4 years have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

D. Kidney disease (stage 1, 2 or 3) or other kidney disorder?	☐	☐
E. Used illegal drugs; alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs)?	☐	☐

During the last 4 years have you:

F. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?	☐	☐

Continued on next page.

12. MEDICAL HISTORY PART 3 (Continued)

Yes No

During the last 2 years have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

G. Heart attack, stroke (CVA) or transient ischemic attack (TIA) ..... ☐ ☐

H. Used insulin; had more than 6 seizures; spina bifida cystica, pancreatitis, tuberculosis; hepatitis B or other liver disease? ☐ ☐

During the last 2 years have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

I. Angina (chest pain); cardiomyopathy; vascular, circulatory or blood disorder (including anemia other than iron deficiency); heart surgery of any kind including bypass surgery, angioplasty, stent implant; irregular heart rhythm such as atrial fibrillation or heart murmur; had an aneurysm surgically corrected; or do you currently have a pacemaker/defibrillator?

☐ Yes ☐ No

if Yes, to Angina

I1. When was the angina (chest pain) first diagnosed?

- ☐ 0-12 months ago
- ☐ 13-24 months ago
- ☐ Greater than 24 months ago

If the answer to I1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count I as a "No" when referring to directions below.

If all questions in Part 3 are answered "No," you are potentially eligible for the Preferred product.
If one question in Part 3 is answered "Yes," you are potentially eligible for the Standard product.
If two or more questions in Part 3 are answered "Yes," you are potentially eligible for the Graded Death Benefit product.

13. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and complete to the best of my knowledge and belief. I acknowledge and agree (A) this application shall consist of the Individual Life Insurance Application, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Producer does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the Owner must have personally received and accepted the policy during the lifetime of each Insured and there must have been no change in the insurability of any Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete. Unless otherwise stated the undersigned Insured is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, Inc. ("MIB"), consumer reporting agency, data aggregator, or any other organization, institution or person, that has any records or knowledge of me or my health/fitness, finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization. I also understand that any credit reporting agency contacted in connection with this authorization may retain and use any information provided about me to the credit reporting agency to the extent that the information is in addition to or more current than the information currently held by such credit reporting agency, and do consent to such use of my information.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice.

This authorization will be valid for 30 months, or the period permitted by applicable law in the state where the policy is delivered or issued for delivery, if shorter. Information released shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in-force. I understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate contestability and eligibility for benefits, the policy's continuation or replacement, the policy's reinstatement, or to contest a claim under the policy.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Owner or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

Continued on next page.