

Application To: 

FAMILY LIFE INSURANCE COMPANY

Policy # _____

1. PROPOSED INSURED: Last Name			First	M.I.	2. Sex <input type="checkbox"/> F <input type="checkbox"/> M	3. Age	4. Birth Date	5. Ht.	6. Wt.	7. Birthplace	
8. Address:					City			State		Zip	
9. Social Security #				10. Driver's License #			11. A.I.R. Driver's License #				
12. Home Phone # ()				13. Work Phone # ()			14. E-mail:				
15. Annual Income:				16. Occupation/Duties:				17. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S			
18. Has any proposed insured used tobacco in any form within the past 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes," describe type and amount _____											
19. BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED: (Unless otherwise noted, the beneficiary of the other persons proposed for coverage will be the owner).											
Beneficiary:				Social Security #			Relationship to Insured:				
Contingent Beneficiary:				Social Security #			Relationship to Insured:				
20. OWNER: (Unless noted, Owner will be Proposed Insured.) Name:							Social Security #				
Address:					Phone # ()			Relationship to Insured:			
21. BASE POLICY INFORMATION: Face Amount: _____ Plan: _____ Term: _____ Guarantee: _____ Death Benefit: <input type="checkbox"/> Level <input type="checkbox"/> Increasing											

22. RIDERS AND BENEFITS:	Amount	Riders and Benefits:	Amount	Riders and Benefits:	Amount
<input type="checkbox"/> a) Waiver of Premium	\$ _____	<input type="checkbox"/> e) Children's Insurance Rider	\$ _____	i) Accident Only Disability	\$ _____
<input type="checkbox"/> b) Accidental Death Benefit	\$ _____	<input type="checkbox"/> f) AIR/Other Insured Rider (1)	\$ _____	<input type="checkbox"/> 12 mos. <input type="checkbox"/> 24 mos. <input type="checkbox"/> 36 mos.	
<input type="checkbox"/> c) Spouse's Accidental Death Benefit	\$ _____	<input type="checkbox"/> g) AIR/Other Insured Rider (2)	\$ _____	j) Critical Illness Rider <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 100%	
<input type="checkbox"/> d) Primary Ins./Term Rider	\$ _____	<input type="checkbox"/> h) Other	\$ _____	k) Return of Premium	<input type="checkbox"/> 100%

23. OTHER INSURED(S):	Sex	Age	Birth Date	Birthplace	Ht./Wt.	Social Security #	Relationship	Tobacco	Occupation
a)	<input type="checkbox"/> F <input type="checkbox"/> M							<input type="checkbox"/> Yes <input type="checkbox"/> No	
b)	<input type="checkbox"/> F <input type="checkbox"/> M							<input type="checkbox"/> Yes <input type="checkbox"/> No	
c)	<input type="checkbox"/> F <input type="checkbox"/> M							<input type="checkbox"/> Yes <input type="checkbox"/> No	

24. BILLING MODE: Monthly Bank Draft (PAC form) Draft Date (not 29, 30, 31) _____ Direct: Annual Semi-Annual Quarterly
 Monthly with Mortgage Payment Loan # _____ Lender: _____

25. MODAL PREMIUM AMOUNT: \$ _____ Total Premium Collected for Receipt \$ _____

26. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: Family Life Insurance Company and its reinsurers may obtain medical and other information in order to evaluate my application for insurance. This may be disclosed by any physician, practitioner, hospital, clinic, medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., or any consumer reporting agency, or any insurance company. The information may involve me, or any care, treatment or advice of me. This includes information relating to alcohol or drug abuse, mental disease or information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Family Life may report such information to the Medical Information Bureau or to other insurance companies to which I have or may apply. This authorization will be valid for 2 years. A photocopy of this will be as valid as the original. I, or my authorized representative may receive a copy of this authorization upon request.

X _____
 Signature of Proposed Insured (or Parent of Insured if Under Age 18) _____ Signature of A.I.R. _____ Date _____

27. AUTHORIZATION FOR AUTOMATIC PAYMENT PLAN: **PLEASE ATTACH A VOIDED PERSONAL CHECK!**
 Family Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the depository institution named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the depository will have a reasonable opportunity to act on such notification. If applicable, I also have the right to receive notice of the reason for any adverse underwriting decision.

Depository Name: _____ Type of Account: Checking Savings
 Depository Address: _____
 Account #: _____ Transit/ABA #: _____
 Name of Policyholder: _____ Signature of Payor: _____ Date: _____

28. PREMIUM PAYMENT REQUEST: Lender: _____ Loan #: _____
 I have applied for insurance through Family Life Insurance Company. If a policy is issued, I will increase the monthly loan payments by an amount equal to the monthly premium for the policy. If a policy has already been issued, I will increase the payments by that amount immediately. I ask you to hold those amounts in my account and pay them to Family Life on my behalf as billed. I understand that you may disclose certain non-public personal financial information to my lender to process this transaction. In the event that you assign my loan to another lender, this request shall be treated as though it were directed to the subsequent lender. (Note to Family Life: In the event that I refinance my loan with another lender, please treat this request as directed to the subsequent lender.) If increased payments are made after the insurance has ended, those payments will not reinstate or continue the insurance. I will be entitled only to have the extra money returned. In receiving the increased payments and paying them to Family Life, you are to act as my agent and not as agent of Family Life. In exchange for your not charging me any fee for handling these premium payments, I agree that no interest will be paid on the increased payments. If borrower and insured are not the same person, the borrower is the Insured's _____

Borrower Name: _____ Signature: _____ Date: _____

COMPLETE THE FOLLOWING: (Check the box with the correct answer and list names and details below.)

- 29. In the last ten years have any of the proposed insured's been diagnosed or treated by a member of the medical profession as having any disease or disorder of:**
- a. the heart or circulatory system including, heart attack, chest pain, palpitations, heart murmur or high blood pressure:..... Yes No
 - b. the brain or nervous system including seizures, fainting, paralysis, stroke, mental illness or dementia; Yes No
 - c. the endocrine system including diabetes, or thyroid; Yes No
 - d. the digestive system including the esophagus, stomach, intestine, liver or pancreas; Yes No
 - e. the respiratory system including; asthma, bronchitis, emphysema; Yes No
 - f. the urinary or reproductive systems including the kidneys, bladder, or prostate; Yes No
 - g. the muscles or bones, such as arthritis; Yes No
 - h. the blood or lymph glands; or for having cancer, a tumor or cyst? Yes No
- 30. In the last ten years have any of the proposed insured's:**
- a. used narcotics, cocaine, hallucinogens, barbiturates, heroin, marijuana or any other drugs not prescribed by a physician;..... Yes No
 - b. been treated, counseled, or joined an organization because of alcohol or drug abuse; Yes No
 - c. been convicted of a felony? Yes No
- 31. In the last five years have any of the proposed insured's:**
- a. been to a hospital, clinic, institution, or had any medical exam, diagnostic test, x-ray, electrocardiogram, surgery, treatment, or advised to have such and did not; Yes No
- b. been or are now disabled; or made a claim for disability as a result of sickness or injury;..... Yes No
 - c. had convictions or citations for motor vehicle violations, or had their driver's license revoked, suspended or limited; Yes No
 - d. participated or plan to participate in any type of racing, sky or scuba diving, mountain or rock climbing, or hang gliding;..... Yes No
 - e. plan on any foreign travel or residence; Yes No
 - f. flown as other than a passenger, or plan to? Yes No
- 32. Has any proposed insured ever tested positive for antibodies to: Acquired-Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?..... Yes No**
- 33. Does the primary proposed insured have a personal physician?**
 Yes No If "Yes" fill in Physician _____
 Address & Phone #: _____
 Last Seen? _____ What Reason? _____
- 34. Have any proposed insured's parents or siblings been diagnosed, treated for, or died from: diabetes, heart disease, circulatory disease, cancer, kidney failure, liver or lung disease? Yes No**
- 35. Does any proposed insured have any existing life or annuity policies?..... Yes No**
- 36. Will insurance now applied for replace any insurance or annuity? Yes No**
- 37. Has any proposed insured: ever had an application for life, accident, disability income, critical illness, long term care or health insurance rated or declined, or have an application for any of these pending? ..Yes No**
- 38. Has any proposed insured had any other physical or mental disorder not listed on this application? Yes No**

39. If questions 29 - 38 are answered "yes", give explanations, dates, names & addresses of physicians & hospital (if any) below.

Proposed Insured	Explanation or Medication	Date	Duration	Hospital	Physician	Address & Phone #
				Yes <input type="checkbox"/> No <input type="checkbox"/>		
				Yes <input type="checkbox"/> No <input type="checkbox"/>		

41. ADDITIONAL REMARKS OR INSTRUCTIONS: (Include additional insured(s) here. Use the L-9 SUP form if additional space is needed.)

HOME OFFICE USE ONLY:

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law. I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice attached to this application. All statements made by or on behalf of the insured or annuitant shall be deemed to be representations and not warranties.

X _____
 Proposed Insured age 15 or more (parent must sign under 15) _____ Date _____ Signed at (City and State) _____

X _____
 Owner(s) (if not Proposed Insured or if they are under age 18) _____ X _____
 Additional Insured(s) age 15 or more _____

AGENT'S STATEMENT: Mail Policy To: Agent Policyholder Best time to call: _____

Agent's E-mail Address: _____ Use E-mail for correspondence? Yes No
 I personally saw did not see each proposed insured. Those not seen are listed above under remarks. To the best of my knowledge and belief, the insurance applied for is is not intended to replace any insurance now in effect. Have exams been scheduled? Yes No

X _____
 Signature of Agent _____ Printed Name _____ Agent # _____ Phone # _____