LIFE INSURANCE APPLICATION - PART 1

(NAME OF INSURANCE COMPANY MUST BE INSERTED BEFORE THIS FORM IS USED)

1. FORM PURPOSE ☐ Formal Application ☐ Informal Inquiry ☐ Change ☐ Other: ______

Case ID

Policy Number (For Changes Only)

2. PRIMARY PRODUCER (Please Print)

First Name: Middle Name:

Last Name:

Producer Number:

BGA Name (If Applicable)

3. INSURANCE APPLIED FOR

Plan Name

Term Plan ☐ 10 YR ☐ 15 YR ☐ 20 YR ☐ Other: ______

Class Applied For

Initial Insurance Amt

Death Benefit Option (Universal Life Policies Only)
[☐ Level - *Specified Amount includes cash value*] [☐ Return of Premium]
[☐ Increasing - *Specified Amount plus cash value*]
[☐ Other: ______]

[Dividend Options (If Applicable)]
☐ Paid Up Additions
☐ Premium Reduction
☐ Accumulation
☐ Cash
☐ Other: ______

Supplemental Coverage (If Applicable to the Selected Plan)
[☐ Accidental Death Benefit $ ______] [☐ Waiver of Premium]
[☐ Accelerated Death Benefits No. of Payments: ______] [☐ Waiver of COI]
[☐ Option to Purchase Addn. Ins. $ ______] [☐ Applicant's Waiver of Premium]
[☐ Spouse Rider $ ______] [☐ Other: ______]
[☐ Child Rider $ ______ or # of Units: ______]

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Purpose of Insurance
Personal ☐ Income Replacement ☐ Estate Conservation ☐ Debt Repayment
Business ☐ Key Person ☐ Stock Redemption ☐ Loan Indemnification
☐ Other: ______

4. PROPOSED INSURED (PI) ☐ **Additional Other Proposed Insured Supplement Attached**

First Name:

Middle Name:

Last Name:

Legal Residence (No P.O. Box)
Line 1:

Line 2:

City: State: Zip: –

Country:

e-mail Address:

Years at Current Address | Date of Birth (mm/dd/yyyy)

Birth State/Province | Birth Country

☐ Male ☐ Female | Height ' " Weight lbs. | Maiden Last Name

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

SSN # / Gov't ID | Drivers Lic # | State

Are you a citizen of the United States? ☐ Yes ☐ No
If no, what is your country of citizenship? ______
What is your visa type? ______
What was your date of arrival in the U.S.? ______

Home Phone ( ) –
Best Time To Call S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐
- OR - From ______ ☐ AM ☐ PM To ______ ☐ AM ☐ PM
Date (mm/dd/yyyy)

Work Phone ( ) – Ext
Best Time To Call S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐
- OR - From ______ ☐ AM ☐ PM To ______ ☐ AM ☐ PM
Date (mm/dd/yyyy)

Employer Name:

Employer Address
Line 1:

Line 2:

City: State: Zip: –

Country:

Years With Current Employer | Annual Income $

Net Worth $

Occupation (Include Duties)

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5. OTHER PROPOSED INSURED (Other PI) ☐ Joint ☐ Rider (If Applicable to the Plan Applied for)

First Name:

Middle Name:

Last Name:

Legal Residence (No P.O. Box)
Line 1:

Line 2:

City: State: Zip: –

Country:

e-mail Address:

Years at Current Address | Date of Birth (mm/dd/yyyy)

☐ Male | Height ' " | Maiden Last Name
☐ Female | Weight lbs.

Birth State/Province | Birth Country

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

SSN # / Gov't ID | Drivers Lic # | State

Are you a citizen of the United States? ☐ Yes ☐ No
If no, what is your country of citizenship?
What is your visa type?
What was your date of arrival in the U.S.?

Relation to Proposed Insured

Home Phone ( ) –
Best Time To Call S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐
- OR - From ________ ☐ AM ☐ PM To ________ ☐ AM ☐ PM
Date (mm/dd/yyyy)

Work Phone ( ) – Ext
Best Time To Call S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐
- OR - From ________ ☐ AM ☐ PM To ________ ☐ AM ☐ PM
Date (mm/dd/yyyy)

Employer Name:

Employer Address
Line 1:

Line 2:

City: State: Zip: –

Country:

Years With Current Employer | Annual Income $

Net Worth $

Occupation (Include Duties)

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6A. OWNER (Complete only if Owner is to be other than Proposed Insured) ☐ Additional Owner Supplement Attached

Owner is: ☐ Individual ☐ Corporation
☐ Sole Proprietorship ☐ Trust
☐ Partnership ☐ Other:

Name of Trustee ____________
Date of Trust Agreement: ____________ (mm/dd/yyyy)

First Name:

Middle Name:

Last Name:

Address
Line 1:

Line 2:

City: State: Zip: –

Country:

Date of Birth (mm/dd/yyyy) | SSN # / FEIN #

Relation to Proposed Insured

If other than individual, give full name:

Are you a citizen of the United States? ☐ Yes ☐ No
If no, what is your country of citizenship? ____________

6B. OTHER OWNER ☐ Joint Owner ☐ Contingent Owner

Owner is: ☐ Individual ☐ Corporation
☐ Sole Proprietorship ☐ Trust
☐ Partnership ☐ Other:

Name of Trustee ____________
Date of Trust Agreement: ____________ (mm/dd/yyyy)

First Name:

Middle Name:

Last Name:

Address
Line 1:

Line 2:

City: State: Zip: –

Country:

Date of Birth (mm/dd/yyyy) | SSN # / FEIN #

Relation to Proposed Insured

If other than individual, give full name:

Are you a citizen of the United States? ☐ Yes ☐ No
If no, what is your country of citizenship? ____________

7A. PRIMARY BENEFICIARY **Irrevocable * ☐ Yes ☐ No** **☐ Additional Beneficiaries Supplement Attached**

Notice: Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Proposed Insured(s) or, if none, by all contingent beneficiaries who survive the Proposed Insured(s). The right to change the beneficiary is reserved to the Owner unless otherwise stated. * Default is "No" if neither box is checked.

First Name:	If other than individual, give full name
Middle Name:	
Last Name:	Address Line 1:
Name of Trustee:	Line 2: City: State: Zip: –
Date of Trust Agreement:	Country:

Date of Birth (mm/dd/yyyy)	SSN # / TIN #	Relation to Proposed Insured	% Share

7B. ADDITIONAL BENEFICIARY **Irrevocable * ☐ Yes ☐ No** **☐ Primary** **☐ Contingent** **☐ Other (Explain in Remarks)**

First Name:	If other than individual, give full name
Middle Name:	
Last Name:	Address Line 1:
Name of Trustee:	Line 2: City: State: Zip: –
Date of Trust Agreement:	Country:

Date of Birth (mm/dd/yyyy)	SSN # / TIN #	Relation to Proposed Insured	% Share

7C. ADDITIONAL BENEFICIARY **Irrevocable * ☐ Yes ☐ No** **☐ Primary** **☐ Contingent** **☐ Other (Explain in Remarks)**

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First Name:	If other than individual, give full name
Middle Name:	
Last Name:	Address Line 1:
Name of Trustee:	Line 2: City: State: Zip: –
Date of Trust Agreement:	Country:

Date of Birth (mm/dd/yyyy)	SSN # / TIN #	Relation to Proposed Insured	% Share

8. OTHER INSURANCE

A. Do any of the proposed insureds have existing or pending life insurance or annuities? (If yes, complete table below.) ☐ Yes ☐ No

B. Has any existing life insurance or annuity been replaced in the last thirteen (13) months, or will any existing values from another policy or annuity (through loans, surrenders, or otherwise), be used to pay premiums for the policy applied for? ☐ Yes ☐ No

Name of Insurance Company	Policy #	Amount	Issue Year	Check All Applicable											
				Policy Type		Ind/Grp		Purpose		Pending		Replace		1035 Exch	
				Life	Annuity	Indiv	Grp	Bus	Pers	Yes	No	Yes	No	Yes	No
PROPOSED INSURED															
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER PROPOSED INSURED															
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. PAYMENT PLAN

Notice: Premium cannot be collected with the application if any of questions 10.i through 10.l in the General Information Section are answered "Yes" or not answered.

Premium Mode: ☐ Annual ☐ Monthly ☐ Semi-Annual ☐ Single ☐ Quarterly ☐ Other: ____________

Non annual premium modes may result in a higher premium outlay per policy year

Payment Method: ☐ EFT ☐ Credit Card ☐ Other: ____________

Billing: ☐ Direct Bill ☐ List Bill ☐ Other:

Premium Quoted $ ____________

Is premium included with application? ☐ Yes ☐ No

If yes, indicate amount. $ ____________

Automatic premium loan? ☐ Yes ☐ No

Payor Name and Address and SSN # / TIN # (If other than owner)

Name: City: State: Zip: –

Line 1: Country:

Line 2: SSN # / TIN #:

All premium checks must be made payable to the Insurance Company. Do not make check payable to the agent or leave the payee blank.

10. GENERAL INFORMATION

Explain all "Yes" responses in Remarks on page 5 of 6

	P I Yes	P I No	Other P I Yes	Other P I No
a) Has any proposed insured ever applied for Life or Disability insurance and been turned down? This question should be excluded in Missouri.	☐	☐	☐	☐
b) Does/Has any proposed insured:				
1) Have an application, informal inquiry or reinstatement request for Life or Disability insurance pending with any other company or society?	☐	☐	☐	☐
2) Ever been asked to pay a higher premium?	☐	☐	☐	☐
3) Ever been issued a reduced face amount?	☐	☐	☐	☐
4) Withdrawn any application or informal inquiry?	☐	☐	☐	☐
c) Has any proposed insured ever used or is currently using tobacco or any other product that contains nicotine?	☐	☐	☐	☐

Type of Product	Quantity		Frequency		Number of Years		Date Last Used	
	P I	**Other P I**	**P I**	**Other P I**	**P I**	**Other P I**	**P I**	**Other P I**
☐ Cigarettes								
☐ Cigars								
☐ Pipe								
☐ Chewing								
☐ Patch								
☐ Gum								
☐ Other								

	P I Yes	P I No	Other P I Yes	Other P I No
d) In the past ten (10) years has any proposed insured requested or received Workers' Compensation, Social Security Disability or other Disability payments, excluding pregnancy related payments?	☐	☐	☐	☐
e) Has any proposed insured ever been convicted of a felony?	☐	☐	☐	☐
f) Within the past five (5) years has any proposed insured:				
1) Had his or her driver's license suspended or revoked?	☐	☐	☐	☐
2) Been convicted of three (3) or more moving violations?	☐	☐	☐	☐
3) Been convicted of reckless driving or driving under the influence of alcohol or drugs?	☐	☐	☐	☐
g) Within the past five (5) years has any proposed insured operated or had any duties aboard an aircraft, glider, hot air balloon, ultralight or similar device; or within the next two (2) years does he/she plan to operate or have any duties? If "yes" complete appropriate supplement.	☐	☐	☐	☐

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10. GENERAL INFORMATION (continued)	P I		Other P I	
Explain all "Yes" responses in Remarks on page 5 of 6	Yes	No	Yes	No
h) Within the past five (5) years has any proposed insured engaged in; or within the next two (2) years does any proposed insured expect to engage in, any hazardous activities or sports such as: cave exploration; mountain, rock or ice climbing; motor vehicle, motorcycle, snowmobile or boat racing; or SCUBA/sky diving? If "yes" complete appropriate supplement.	☐	☐	☐	☐
i) Within the next two (2) years, does any proposed insured plan to travel or reside outside of the United States?	☐	☐	☐	☐
j) Within the past 90 days, has any proposed insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended or been advised to have a diagnostic test other than an HIV (Human Immunodeficiency Virus) test?	☐	☐	☐	☐
k) Has any proposed insured ever used cocaine or any other controlled substances (other than as prescribed by a physician) or has any proposed insured been counseled, treated or hospitalized for drug use?	☐	☐	☐	☐
l) Within the past ten (10) years, has any proposed insured had or been treated for heart disorder, heart disease, angina, stroke, hypertension, high blood pressure, diabetes or cancer?	☐	☐	☐	☐

Do not submit payment with the application if any of questions 10.j through 10.l are answered "YES" or not answered.

Secondary Addressee for Purpose of Notification of Past Due Premium Payment and Possible Lapse in Coverage (FL, NY only)

Name:

Line 1: City: State: Zip: –

Line 2: Country:

REMARKS

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11. SIGNATURE

Understanding and Agreement

I have read this entire application including any attachments and understand the insurance will become effective upon the date as defined in the attached Policy Effective Date Supplement which is part of this application. I declare to the best of my knowledge and belief that all of the statements in the application, including any attachments, are complete, true and accurate. All questions were asked of me and if applicable, the additional/joint insured(s) and parent(s) or guardian(s) of any children listed in this application. I agree that I will notify the insurer if any statement or answer given in this application changes prior to policy delivery.

I understand that no licensed insurance agent is authorized to: make or modify contracts; waive any Insurer rights or requirements; or waive any information the Insurer requests.

☐ **Policy Effective Date Supplement Attached**

Taxpayer Identification Number

"The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to backup withholding."

Under penalties of perjury, I as policyowner, certify that my correct taxpayer identification number is shown on this form. I am not subject to backup withholding for the following reasons:

a) I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or
b) The IRS has notified me that I am no longer subject to backup withholding, or
c) I am exempt from backup withholding.

Complete the following, if applicable:

☐ I have been notified by the IRS that I am subject to backup withholding due to the underreporting of interest or dividends.
☐ I am not a U.S. citizen or U.S. resident alien.

City and state where application was signed

State where policy will be delivered (if different from state where application was signed)

Signature of Proposed Insured	Date (mm/dd/yyyy)
Signature of: ☐ Proposed Insured ☐ Owner If other than Proposed Insured ☐ Applicant If other than Proposed Insured	Date (mm/dd/yyyy)
Signature of: ☐ Proposed Insured ☐ Owner If other than Proposed Insured ☐ Applicant If other than Proposed Insured	Date (mm/dd/yyyy)
Signature of: ☐ Proposed Insured ☐ Owner If other than Proposed Insured ☐ Applicant If other than Proposed Insured	Date (mm/dd/yyyy)

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FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. (Not applicable in CO, FL, HI, MD, NE, NY, OH, OK, OR, VA or VT)

In FLORIDA, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In VIRGINIA and MARYLAND, any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application for insurance or files a claim containing a false or deceptive statement may have violated state law.

12. PRODUCER STATEMENT

a) Do any of the Proposed Insureds have any existing life insurance or annuities? ☐ Yes ☐ No

b) To the best of your knowledge, will any existing life insurance or annuity be replaced or will values from another insurance policy or annuity (through loans, surrenders or otherwise) be used to pay premiums for the policy applied for? ☐ Yes ☐ No

If Application was translated check box ☐	Name of Translator
Producer Name (Please Print)	State License Identification Number
Signature of Producer	Date (mm/dd/yyyy)