John Hancock

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Application For Individual Life Insurance

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

If applying for Survivorship Coverage, please also complete *Survivorship Supplement for Second Life ICC16 NB6001.*
Print and use black ink. Any changes must be initialed by the Proposed Insured and the Policy Owner.

IMPORTANT NOTICE: Your application is a critical source of information for consideration of your request for insurance coverage. Therefore:

- We strongly urge you to be complete and accurate in your responses so that we may provide you with the best coverage we can.
- If we determine that your answers on this application are incorrect, incomplete, or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage.

SECTION A: Proposed Insured

1. Name — FIRST | MIDDLE | LAST
Maxim BLa

2. Sex
☒ Male ☐ Female

3. Date of Birth
MONTH DAY YEAR

4. Place of Birth — STATE/COUNTRY
afcaac

5. Social Security Number
1 2 3 4 5 6 7 8 9

6. Driver's License Number/State

7. Citizenship
☐ US ☒ Non US - Country of Citizenship _____
Type of Green Card/VISA _____

8. Primary Residence — STREET ADDRESS | CITY | STATE | ZIP CODE

9. Telephone Numbers
PERSONAL BUSINESS

10. Email Address ! *Your email is required so we may communicate with you about your policy online*

11. Occupation
☐ Job/Duties _____ Employed by _____
☒ Student ☐ Homemaker ☐ Unemployed ☐ Retired ☐ Other _____

12. Are you currently a member of the armed forces, including the reserves?
☒ Yes ☐ No ! *If Yes, complete Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109*

13. Gross Annual Household Income
Salary $ _____ Other $ _____

14. Household Net Worth
$ _____

15. In the last 5 years, has the Proposed Insured or any business of which he/she is a partner/owner/executive been bankrupt, had any liens, or judgements?
☐ Yes ☒ No - *If Yes, provide details* _____

SECTION B: Policy Owner

- Complete if Policy Owner is someone other than the Proposed Insured
- List additional Policy Owners and details in *SECTION K: ADDITIONAL INFORMATION*

16. a. Policy Owner Type

☐ Individual ☐ Business ☐ Existing Trust ☐ Trust to be Established

If Trust Owner, complete the Trust Certification PS5101

If Partnership Owner, complete the Partnership Statement PS7800US

☐ Other _____

b. Policy Owner Relationship

☐ Spouse ☐ Child ☐ Trust

☐ Business Partner ☐ Employer

☐ Other _____

c. Name or Entity/Trust Name FIRST MIDDLE LAST

d. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Address STREET ADDRESS CITY STATE ZIP CODE

g. Telephone Number

h. Email Address

17. Multiple Policy Owners - Type of Ownership ☐ Joint with right of survivorship ☐ Tenants in common

18. Is the Policy Owner a Non US Person or a Non Resident Alien?

☐ Yes ☐ No *If Yes, Complete IRS Form W-8BEN for individuals*

SECTION C: Beneficiary Information

- This section is to be completed by Policy Owner
- Beneficiary listed in question 19 is always assigned as Primary
- List additional beneficiaries in *SECTION K: ADDITIONAL INFORMATION*

19. a. Name or Entity/Trust Name FIRST MIDDLE LAST

b. Percentage _____ %

c. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner

☐ Employer ☐ Other _____

d. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Telephone Number

g. Email Address

h. Address STREET ADDRESS CITY STATE ZIP CODE

20. a. Name or Entity/Trust Name FIRST MIDDLE LAST

b. Percentage _____ %

c.

☐ Primary

☐ Secondary

d. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner

☐ Employer ☐ Other _____

e. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

f. Social Security OR Tax ID

☐ SSN

☐ Tax ID

g. Telephone Number

h. Email Address

i. Address STREET ADDRESS CITY STATE ZIP CODE

SECTION D: Coverage Details

- This section is to be completed by Policy Owner
- Refer to your illustration for riders and benefits selected

21. Product Name *(see Policy Illustration Summary Page)* _____

22. Flexible Premium Products

☐ Universal Life ❗ *If applying for Indexed UL, complete Premium Allocation Instructions ICC16 NB6017*

☐ Variable Universal Life ❗ *Complete Fund Allocation ICC16 NB6016*

a. ☐ Single Life

☐ Survivorship ❗ *Complete Survivorship Supplement for Second Life ICC16 NB6001*

b. ☐ Base Face Amount $ _____

☐ Supplemental Face Amount $ _____ (not available with all products)

☐ Level ☐ Increasing by _____ % for _____ Years

☐ Customized Increasing Schedule ❗ *Complete Customized Schedule NB5064*

c. Death Benefit Option

☐ Option 1 (Death Benefit = Face Amount) ☐ Option 2 (Death Benefit = Face Amount + Policy Value)

d. Life Insurance Qualification Test

☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation (CVAT)

e. Riders and Benefits (*Refer to instruction page for riders and benefits available per product*)

☐ Healthy Engagement Rider (Vitality)

☐ Long-Term Care Rider ❗ *Complete Application Supplement (Long-Term Care Rider) ICC13 NB5018*

☐ Accelerated Death Benefit (for terminal illness) ❗ *Complete Summary and Disclosure Statement for Accelerated Benefit NB1237*

☐ Cash Value Enhancement Rider

☐ Disability Payment of Specified Premium Rider

☐ Disability Waiver of Monthly Deductions Rider

☐ Estate Preservation Rider

☐ Extended No-Lapse Guarantee Rider ❗ *Not all fund investment options are available with this rider*

☐ Overloan Protection Rider

☐ Policy Split Option Rider

☐ Return of Premium Rider *(Death Benefit Option 1 only)*

☐ Other _____

23. Term Products

☐ Term: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ Other _____

☐ Healthy Engagement (Vitality) Term: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ Other _____

a. Face Amount $ _____

b. Riders and Benefits (if applicable)

☐ Total Disability Waiver

☐ Accelerated Death Benefit (for terminal illness)

❗ *Complete Summary and Disclosure Statement for Accelerated Benefit NB1237*

☐ Conversion Extension Rider (15 Year Term and 20 Year Term Only)

☐ Other _____

24. If an additional or optional policy is being applied for by the Policy Owner in a separate application, state plan and face amount.

Plan Name _____ Face Amount $ _____

SECTION E: Purpose and Funding Information

- This section is to be completed by Policy Owner
- List additional information in *SECTION K: ADDITIONAL INFORMATION*
- All Premium Notices and Correspondence are sent to the Policy Owner at the address provided in Section B

25. a. Billing Method

☐ Pre-Authorized Payment Plan ! *Complete Request for Pre-Authorized Payment Plan NB5087*

☐ Direct Bill (not available for monthly billing)

b. Please select billing frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Pre-Authorized Payment Plan only)

26. Existing Life Insurance

a. Does the Policy Owner have any existing life insurance and/or annuities with this or any other company?

☐ Yes ! *If Yes, refer to the Instructions for Application for Individual Life Insurance regarding additional required Replacement forms*

☐ No

b. Will this insurance replace any existing life insurance policies and/or annuities, or are you, the Policy Owner, considering using funds from existing policies or annuities to pay premiums on the new policy?

☐ Yes ! *If Yes, refer to the Instructions for Application for Individual Life Insurance regarding additional required Replacement forms*

☐ No

27. Purpose of Insurance

☐ Income Replacement ☐ Estate Planning

☐ Business Insurance ! *Complete Financial Supplement for Business Insurance ICC16 NB6014*

☐ Other - give details _____

28. Lapse Notification Handling

Secondary Addressee: In addition to the Policy Owner, The Company will mail lapse notices for overdue premiums to any Secondary Addressee you designate. If you want this option, provide the following information for the Secondary Addressee:

a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

c. Address STREET ADDRESS CITY STATE ZIP CODE

29. a. Other than the Policy Owner, Proposed Insured(s) and beneficiaries specified herein, does or will any person or entity have any right, title or interest in any policy issued as a result of this application?

☐ Yes ☐ No - If Yes, give details _____

b. Have you been offered money or other consideration by any person or entity in connection with this application?

☐ Yes ☐ No - If Yes, give details _____

30. Premium (Payment) Source

☐ Income

☐ Liquidated Assets - give details _____

☐ Proceeds from Sold or Viaticated policy - give details _____

☐ Loan ! *If you checked Loan, complete Question 31 a, b, and c on next page*

☐ Other - give details _____

SECTION E: Purpose And Funding Information *continues on next page*

SECTION E: Purpose And Funding Information (continued)

Only complete question 31, a, b and c if 'Loan' was selected in question 30

31. a. Name all lenders involved

b. What amount and type of collateral is required to secure the loan and/or loans?

Amount $ _____ Type of collateral _____

c. In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?

☐ Yes ☐ No - If Yes, give details _____

SECTION F: Existing, Replacement, And Pending Insurance Information

- This section is to be completed by Proposed Insured
- List additional policies in *SECTION K: ADDITIONAL INFORMATION*

32. a. Is the Proposed Insured under this application also an insured on any other existing life insurance policy, including any policy that has been sold, assigned, transferred or settled?

☐ Yes ☐ No ❗ *If you checked Yes, complete Question 32b*

b. If Yes, provide details for each existing Life Insurance policy on the Proposed Insured with all companies

INSURANCE COMPANY	INSURANCE PURPOSE		YEAR ISSUED	SURVIVORSHIP		TO BE REPLACED		1035 EXCHANGE		SOLD, ASSIGNED TRANSFERRED OR SETTLED		FACE AMOUNT INCLUDING RIDERS
	PERSONAL	BUSINESS		YES	NO	YES	NO	YES	NO	YES	YEAR	
	☐	☐		☒	☐	☒	☐	☒	☐	☒		$
	☐	☐		☐	☒	☐	☒	☐	☒	☐		$

33. a. If life insurance coverage is being applied for on the Proposed Insured with any other company, provide the face amount of all applications and name of the life insurance company. Do not include informal inquiries.
If "None" check this box ☐

INSURANCE COMPANY	FACE AMOUNT INCLUDING RIDERS
	$
	$

b. What is the total amount of new Life Insurance coverage that you plan to accept with all companies including this application? $_____

SECTION G: Personal Information

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

34. The information you provide in this application is critical to our consideration of your request for insurance coverage. You are strongly urged to answer all questions completely and accurately so that we may provide you with the best coverage we can. We will seek information from other sources to assist us with evaluating your application, potentially including your health care provider. If your answers are incorrect, incomplete or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage. Please know that your personal information, including health information, is protected by The Company and only used by The Company to do business with you, and as permitted or required by law.

X _____ Initial here to acknowledge that you have carefully reviewed and fully understand the above statement.

35. a. Primary Physician Name FIRST LAST ☐ Check if Proposed Insured does not have a physician

b. Address STREET ADDRESS CITY STATE ZIP CODE c. Telephone Number

d. Date of last visit MONTH DAY YEAR

e. Reason for last visit, outcome and treatment prescribed

36. a. Name of Medical Group/Health Care Provider (if applicable)

b. Name of Health Insurance Provider (if applicable)

37. Provide name, address, and phone number of any other specialists or member of the medical profession consulted in the past 24 months.

• *If you need more space, continue listing in SECTION K: ADDITIONAL INFORMATION.*

38. In the past 18 months, have you visited a dentist or hygienist for routine dental care?

☐ Yes ☐ No

39. Describe your complete tobacco/nicotine products usage history, including but not limited to: cigarettes, e-cigarettes, cigars, pipe, chewing tobacco, snuff, hookah, nicotine patch, nicotine gum.
NOTE: Tobacco use does not automatically nor necessarily result in denial of coverage.

• *If products used exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF PRODUCT	QUANTITY AND UNIT (Ex. Packs, cigarettes, patches, etc.)	FREQUENCY	DATE LAST USED (MONTH/YEAR)
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	

☐ I have never used nicotine/tobacco products

SECTION G: Personal Information *continues on next page*

SECTION G: Personal Information (continued)

40. Describe your marijuana use in the past 5 years.

NOTE: Marijuana use does not automatically nor necessarily result in denial of coverage

PURPOSE

☐ Recreational/Social

☐ Medicinal – Provide Prescription Card ID _____

Date Last Used

MONTH YEAR

FREQUENCY

_____ times per ☐ Day ☐ Month ☐ Year

DELIVERY METHOD

☐ Ingested ☐ Vaporized ☐ Inhaled

☐ I have not used marijuana in the past 5 years

SECTION H: Lifestyle Information

• This section is to be completed by Proposed Insured as it pertains to his or her own lifestyle history

41. Describe your exercise routine, such as walking, running, treadmill, swimming, aerobics, strength training, cycling, sports or yoga.

• *If exercises exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF EXERCISE	FREQUENCY	TIME SPENT PER SESSION
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes

☐ I do not participate in an exercise routine

42. Have you ever had an application for life insurance declined, postponed, rated substandard, modified, requiring extra premium, or offered less than applied for by any company?

☐ Yes ☐ No

If Yes, give details of decision type, reason and date _____

43. In the past 12 months, have you missed more than 10 consecutive days of work, school, or your daily/regular activities because of illness, injury, or medical treatment?

☐ Yes ☐ No

If Yes, provide details _____

SECTION H: Lifestyle Information *continues on next page*

SECTION H: Lifestyle Information (continued)

44. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?

☐ Yes ☐ No

If Yes, give details of location (city/country), purpose, frequency and duration _____

45. Have you ever flown or intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes?

☐ Yes ☐ No ❗ *If Yes, complete Aviation Questionnaire ICC16 NB6009*

46. Please indicate any of the following activities you participate in or have participated in, within the last 2 years:

☐ Motorcycle racing ☐ Scuba diving ☐ Power boat racing ☐ Skydiving/Parachuting
☐ Mountain climbing ☐ Ballooning ☐ Hang-gliding ☐ Backcountry skiing/snowmobiling
☐ Bungee/base jumping ☐ Heli skiing ☐ Motor vehicle racing ☐ I do not participate in any of these activities

❗ *If any activities selected, complete Avocation Questionnaire ICC16 NB6010*

47. Please indicate which of the following apply to your driving history:

☐ Convicted of 1 or more moving violations in the past 2 years ☐ Convicted of driving while intoxicated or otherwise impaired
☐ License is currently revoked or suspended ☐ None of these apply to me

48. Have you ever been convicted of, plead guilty for, or are you currently awaiting trial for any infraction, misdemeanor or felony?

☐ Yes ☐ No

If Yes, give details of type, date, city/state of felony and/or crime and if currently on probation or parole

SECTION I: Juvenile Insurance

• Complete only if Proposed Insured is under age 18

49. a. Are all siblings equally insured?

☐ Yes ☐ No

If No, give details _____

b. Amount of life insurance currently in force or pending for:

Mother $_____ If none, provide reason: _____

Father $_____ If none, provide reason: _____

Guardian $_____ If none, provide reason: _____

SECTION J: Temporary Life Insurance Agreement Application

- You may be eligible for Temporary Life Insurance Coverage. Please speak with your Agent/Representative for details on the amount and benefit period. This section is to be completed only if you are applying for Temporary Life Insurance.

Instructions for Agent/Representative

- Money may only be collected with this application and the Temporary Life Insurance Receipt and Agreement ICC16 NB6004 may only be issued if:
  1. questions 50, 51 and 52 are answered "No"
  2. the Proposed Insured is age 20 to 70
  3. the amount applied for under this application is not greater than $10,000,000 (single life) or $15,000,000 (survivorship)

  Note: Temporary Life Insurance questions must be answered by both insureds if Survivorship coverage is being applied for. See *Survivorship Supplement for Second Life ICC16 NB6001*.

50. Within the last 24 months, has the Proposed Insured under this application:	PROPOSED INSURED
a. consulted a member of the medical profession for, been diagnosed with or been treated for any heart problem, stroke or cancer?	☐ Yes ☐ No
b. received a recommendation (excluding HIV) from a member of the medical profession for any consultation, testing, investigation or surgery that has not yet been completed?	☐ Yes ☐ No
c. been declined for life insurance?	☐ Yes ☐ No
51. Other than planned routine check-ups, in the last 24 months have there been any pending medical tests or follow-up for medical concerns or symptoms (excluding HIV) for which a medical professional should be consulted?	☐ Yes ☐ No
52. Does the Proposed Insured reside outside the United States more than 6 months per year?	☐ Yes ☐ No

SECTION K: Additional Information

- This is an additional section if more space is required for any of the previous sections, e.g. listing additional beneficiaries from SECTION C, listing additional policies from SECTION F, listing additional tobacco products from SECTION G, etc.

SECTION	QUESTION NUMBER	DETAILS

SECTION L: Special Instructions

Read the following carefully and sign next page

DECLARATIONS

The Proposed Insured (or Parent or Guardian) and Policy Owner declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of their knowledge and belief. All such statements and answers are representations, not warranties.

In addition, I/we understand and agree that:

1. **Policy Application:** The statements and answers in this application, which include any supplemental form relating to health, aviation practices or lifestyle of the Proposed Insured, will become part of the insurance policy issued as a result of this application. No information about me will be considered to have been given to The Company unless it is stated in the application or any form that is made part hereof.
2. **Policy Effective Date:**
   - **a)** Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered to the Policy Owner, provided that the Proposed Insured is still living and nothing has occurred that would require a change in any statement or answer in any part of the application, including any supplemental forms, in order to make the statement or answer true and complete as of the date this policy becomes effective. If there has been such an occurrence: (i) if there is no Temporary Life Insurance Agreement (TIA) coverage, the policy will not be put into effect, and (ii) if there is TIA coverage and the TIA has not ended, the policy will be put into effect but only to the limit of the TIA coverage amount.
   - **b)** If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided under the TIA and according to its terms.
   - **c)** Only an officer of The Company may make, modify, or discharge any insurance contract on its behalf. No agent has the authority to: (i) accept risks; (ii) determine insurability; (iii) make or modify any contractual provision; or (iv) waive any of The Company's rights or requirements.
3. **Employer Owned Policies:** The Proposed Insured confirms that they have received, prior to issue, written notice that indicates: (i) the employer's intent to insure the Proposed Insured, (ii) the maximum amount of the insurance to be issued on the life of the Proposed Insured and (iii) that the employer will be the beneficiary of the new policy. The Proposed Insured also confirms that they have provided written consent to being insured and that such coverage may continue after employment terminates.
4. **Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
5. **Variable Policies: I/We acknowledge that the policy values that are based on the separate account assets are not guaranteed and will decrease or increase with investment experience.** I/We acknowledge receipt of the current prospectuses and supplements that describe the variable life insurance policy applied for and the sub-accounts of the separate account that are available under this policy. I/We have reviewed the prospectuses and supplements and believe that the variable life policy is consistent with my/our insurance needs, investment objectives and investment risk tolerance.
6. **Flexible Premium Policies**: I/We understand that I/we may need to pay additional premiums in addition to the Planned Premium if the current policy charges or actual interest rate credited/investment performance are different from the assumptions used in the illustration (assuming the requirements of any applicable guaranteed death benefit feature have not been satisfied).
7. **Temporary Insurance Coverage:** If coverage under a TIA is applied for, I have received, read and understand the terms and conditions of the Temporary Life Insurance Receipt and Agreement ICC16 NB6004.
8. **Healthy Engagement Benefit:** If a policy is issued with the Healthy Engagement rider or benefit (the Benefit), the Proposed Insured will receive a membership in a healthy engagement program offered by a third party program provider. By applying for the Benefit, the Proposed Insured authorizes The Company to share his/her personal information, including certain health information, with the provider in connection with the registration for the program and administration of the Benefit. The Proposed Insured understands and agrees that (i) his/her program membership will be subject to the provider's privacy policy and terms and conditions of membership, which the Proposed Insured should read prior to joining the program, and (ii) he/she will be asked to authorize the provider to share his/her health, lifestyle, medical or other personal information with The Company. The Proposed Insured will not be eligible to participate in the program if the terms and conditions of membership are not accepted. Upon termination of the policy or rider, as applicable, the program membership will terminate and access to further benefits and incentives, if any, will cease as provided in the terms and conditions. The Company is not responsible or liable for any damage, loss or injury arising out of the Proposed Insured's participation in any third party healthy engagement programs or receipt of any products or services provided through such programs.

Read carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me.

2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, the MIB, Inc. ("MIB") or any other similar person or organization to disclose health information about me or any minor child who is to be insured. Health information includes: (i) my entire medical record and medical history, prescription history, and other health information; (ii) confidential information related to Human Immunodeficiency Virus (HIV), other communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to disclose financial/net worth information about me.

Such disclosure of my information may be made to The Company, its affiliated companies, agents, service providers, reinsurers, MIB or any person or entity entitled to receive such information by law or as I may further consent.

Information collected under this authorization will be used to evaluate my application for insurance, identify any misrepresentation in the information provided by me in this application, administer coverage, evaluate a claim for benefits, for reinsurance or other insurance purposes, or to conduct other legally permissible activities. I authorize The Company, or its reinsurers, to make a brief report of my health information to MIB.

This authorization is valid for 24 months from the date shown below or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter. A photocopy of this authorization will be as valid as the original. I am entitled, or my authorized representative is entitled, to a copy of this authorization.

I understand that I can revoke this permission to collect information at any time by providing written notification to John Hancock Life Insurance Company (U.S.A.) at the Service Office address (page 1) Attention: Chief Underwriter, but any revocation will not affect such information that has already been collected and relied on by The Company.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB.

SIGNATURES – *If Proposed Insured is under age 15, Parent or Guardian must sign on the Proposed Insured Signature Line and include relationship*

X _____

SIGNATURE OF POLICY OWNER (PROVIDE TITLE OR CORPORATE SEAL, IF SIGNING OFFICER)

_____

POLICY OWNER - SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF PROPOSED INSURED IF OTHER THAN POLICY OWNER (PARENT OR GUARDIAN IF UNDER AGE 15)

AGENT SIGNATURE

I certify that all the information supplied by the Proposed Insured and Owner(s) has truly and accurately been recorded on the application.

X _____ _____

SIGNATURE OF AGENT/REPRESENTATIVE DATE