Application for Whole Life Insurance (Form L-0018)

NEW ERA LIFE INSURANCE COMPANY OF THE MIDWEST ● P.O. BOX 4884, HOUSTON, TX 77210-4884 ● 281-368-7200 ● 1-877-368-4692

Section A General Information (*Please Print*)

Proposed Insured's Name:		❒ Male ❒ Female	Requested Effective Date:	
Daytime Phone:		Social Security #:		
Address:		City:	State:	Zip Code:
Birthdate:	State or Country of Birth:	Height (ft./in):	Weight (lbs.):	
Primary Beneficiary:		Social Security #:	Relationship:	Birthdate:
Address:		City:	State:	Zip Code:
Contingent Beneficiary:		Social Security #:	Relationship:	Birthdate:
Address:		City:	State:	Zip Code:
Owner (If other than Proposed Insured):		Social Security #:	Relationship:	Birthdate:
Address:		City:	State:	Zip Code:

Will proposed insurance replace any existing life insurance or annuity? ❒ Yes ❒ No *If "Yes", please complete information below.*

Existing Coverage Insurer's Name:	Policy/Certificate #:	Plan Type:	Maximum Benefits:	Termination Date:

Within the past 24 months, have you used tobacco in any form? ❒ Yes ❒ No

Section B Modified Benefit Qualifying Section

If any question in **Section B** is answered "**Yes**", the proposed insured is not eligible for any coverage.

1. Are you currently hospitalized, bedridden, confined to a nursing facility, receiving hospice home health care, or confined to a wheelchair?	❒ Yes ❒ No
2. Have you ever been diagnosed or treated for (including prescription medications): congestive heart failure, peripheral neuropathy, organ transplant, Alzheimer's disease, dementia, ALS (Lou Gehrig's disease), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	❒ Yes ❒ No
3. In the past 12 months, have you been diagnosed or hospitalized for: kidney dialysis, heart attack, stroke, or Transient Ischemic Attack (TIA), aneurysm, angina pectoris, or any heart procedure to improve coronary circulation including, but not limited to stents?	❒ Yes ❒ No
4. In the past 24 months, have you been diagnosed or been treated for (including prescription medications): internal cancer or melanoma?	❒ Yes ❒ No
5. In the past 12 months, have you had, or been treated for (including prescription medications): alcoholism and/or drug addiction, Chronic Obstructive Pulmonary Disease (COPD), or used oxygen to assist in breathing?	❒ Yes ❒ No
6. Have you had an application for life insurance rejected in the past 6 months?	❒ Yes ❒ No

Section C Standard Level Benefit Qualifying Section

Complete **Section C** only if every question in **Section B** was answered "**No**".

1. Within the past 24 months, have you been treated for (including prescription medications), or been advised to receive treatment for: heart attack, stroke, Transient Ischemic Attack (TIA), lung disease or disorder, liver disease or disorder, neuro-muscular disease, Cirrhosis, emphysema or Chronic Obstructive Pulmonary Disease (COPD), kidney failure or had any heart procedure to improve coronary circulation?	❒ Yes ❒ No
2. Within the past 24 months, have you had, or been advised to receive treatment for (including prescription medications):	
a) Alcohol and/or drug use?	❒ Yes ❒ No
b) Insulin dependent diabetes?	❒ Yes ❒ No
c) Parkinson's disease, multiple sclerosis, or systemic lupus erythematosus?	❒ Yes ❒ No
3. Within the past 48 months, have you been diagnosed or been treated for (including prescription medications), or advised to receive treatment for internal cancer or Melanoma?	❒ Yes ❒ No
4. Does your weight exceed the maximum weight on the Maximum Weight Table below?	❒ Yes ❒ No

MAXIMUM WEIGHT TABLE																			
Height	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
Weight (lbs)	200	205	215	220	225	230	235	240	250	255	265	270	280	285	295	305	315	320	335

IF ANY QUESTION IN SECTION C IS ANSWERED "YES" THE PROPOSED INSURED QUALIFIES ONLY FOR THE MODIFIED BENEFIT PLAN. IF ALL QUESTIONS IN SECTION B & C ARE ANSWERED "NO" THE PROPOSED INSURED QUALIFIES FOR THE STANDARD LEVEL BENEFIT PLAN.

Name, Address and Phone Number of Personal Physician:

Section D Plan and Premium Information

Plan: ❒ Standard (Immediate Full Death Benefit) ❒ Modified (Modified Death Benefit)

Face Amount: $_____ Premium: $_____

Automatic Premium Loan: ❒ Yes ❒ No

Premium Mode: *PAC only:* ❒ Monthly - from account indicated below

Direct Bill or PAC: ❒ Annual ❒ Semi-Annual

I hereby apply to New Era Life Insurance Company of the Midwest for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of New Era Life Insurance Company of the Midwest to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of Human Immunodeficiency Virus (HIV) (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of a Human Immunodeficiency Virus-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to New Era Life Insurance Company of the Midwest or it's representative or it's reinsurers upon presenting this authorization or a photocopy. New Era Life Insurance Company of the Midwest or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to New Era Life Insurance Company of the Midwest and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Notice Regarding Replacement form if this is a replacement. I have received and read the conditional receipt. It has been explained to me by the agent. I understand and agree to all the conditions and limitations.

Any person who knowingly and with intent to defraud any insurance company or other 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 may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

X _____	_____	_____
Proposed Insured's Signature	Signed at (City and State)	Date
X _____	_____	_____
Witness (Licensed Resident Agent)	Owner, if other than Proposed Insured	Date

Pre-Authorization (PAC) Check Payment Plan (Attach voided check or deposit slip)

Your Name *(as it appears on your bank account)*_____
Account Number_____
Name of Financial Institution (Bank)_____
Address of Financial Institution (Bank)_____

I hereby authorize New Era Life Insurance Company of the Midwest to initiate debit entries to my account indicated above, and I authorize the Financial Institution named above to charge the amount of such entries to my account. I further authorize Company to initiate credits to my account to correct errors, and Institution to deposit any such corrections to my account.

This authority is to remain in full force and effect until I revoke the agreement as hereafter provided. Any revocation is effective only after Company has received written notice from me to terminate this agreement in such time and manner to afford a reasonable opportunity to act upon the notice. I have the right to stop payment of a debit entry by notification to Institution in such time and manner to afford a reasonable opportunity to act prior to charging the account.

✕	✕	
Signature	Second Signature for Joint Account	Date

Telephone Interview Information

New Era Life Insurance Company of the Midwest reserves the right to conduct a telephone interview ("Personal History Interview") directly with the Proposed Insured. Please assist us in completing the interview by providing the following information:

Best time to call: ❒ AM ❒ PM ☎Phone: (_____) _____-_____ ❒ Home ❒ Work

Agent Information

I certify that I have personally asked each question on the application to the applicant and have truly and accurately recorded the answers provided. To the best of my knowledge, replacement of an existing policy ❒ IS ❒ IS NOT involved in this transaction.

Agent_____ Percent _____ License No. _____

Agent_____ Percent _____ License No. _____

Tear Along the Dotted Line

Conditional Receipt

Received from: _____ for Life Insurance.

Payment is: $_____ ❒ Cash ❒ Check

IMPORTANT: No insurance will be effective until your application is approved and the policy is issued. The agent cannot accept risk or waive any of the Company's rights or requirements. This receipt is not valid unless it is signed by an agent of the Company, the Proposed Insured and the Owner.

All premium checks shall be made payable to New Era Life Insurance Company of the Midwest
Do not make checks payable to the agent or leave the payee blank
SIGNATURE IS REQUIRED

✕		✕	✕
Proposed Insured's Signature	Date	Agent	Owner, if other than Proposed Insured