[Lumico
insurance made clear]

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Lumico Life Insurance Company
Home Office: [237 E High Street, Jefferson City, MO 65101]
Administrative Office: [P.O. Box 83303, Lincoln, NE 68501-3303]

Proposed Insured's Personal Information

First name	[**Middle name**]	**Last name**

Gender (Select one) ☐ Male ☐ Female	Birth Date (mm/dd/yyyy)	[Birth State & Country]	[Social Security Number]

Residence Street Address	City	State	Zip Code

[Mailing Street Address]	[City]	[State]	[Zip Code]

[E-mail Address]	[Phone number] [☐ Mobile] [☐ Home]

[Driver's License Number]	[State of Issue]	[Family status (single, couple, single with child(ren), couple with child(ren))]

[Occupation]	[Annual income(including bonuses)]

[Are you a United States citizen? ☐ Yes ☐ No; or do you have Permanent Resident (Green Card) status? ☐ Yes ☐ No]

[Owner [(Complete only if Owner is different from the Proposed Insured)]]

First name	[**Middle name**]	**Last name**

[Relationship to Insured]	[Social Security Number]

[Residence Street Address]	[City]	[State]	[Zip Code]

[Mailing Address] | [City] | [State] | [Zip Code]

[E-mail Address] | [Phone number] [☐ Mobile] [☐ Home]

[Are you a United States citizen? ☐ Yes ☐ No; or do you have Permanent Resident (Green Card) status? ☐ Yes ☐ No]

]

Coverage

Type	Coverage Amount	Riders
[☐ 10 year level term ☐ 15 year level term ☐ 20 year level term ☐ 30 year level term]	$	[☐ Dependent Child $_____ ☐ Accidental Death Benefit $_____ ☐ Waiver of Premium $ _____ ☐ _____]

[Initial Payment Amount
$]

[**Dependent Child Rider**

Coverage Amount
$

First Name	Last Name	Date of birth (mm/dd/yyyy):	[Social Security Number]

]

Other Coverage

Do you have any existing life insurance or annuity contracts in force with this company or any other company?

☐ Yes ☐ No

If yes, please indicate combined amount of existing coverage: $

Have you ever had an application or reinstatement request for life, health or disability insurance declined or postponed?

☐ Yes ☐ No

Will the policy that you are applying for replace, terminate or change any life insurance policies or annuity contracts you have?

☐ Yes ☐ No

If YES, please provide details:

Insurance Company Name	Type of Policy	Policy Number	Amount

Beneficiary Information

Primary Beneficiaries

Full Name	Address	Date of Birth (mm/dd/yyyy)	[Social Security Number]	Relationship to Insured	% (total must add to 100%)

Contingent Beneficiaries

Full Name	Address	Date of Birth (mm/dd/yyyy)	[Social Security Number]	Relationship to Insured	% (total must add to 100%)

Proposed Insured Personal and Medical History

[I declare that all of the following statements and answers I provide in this application are true and complete to the best of my knowledge and belief. ☐ Yes ☐ No]

[1]	[In the last 12 months, how often have you used tobacco or nicotine products including any electronic nicotine delivery systems such as e-cigarettes or vaping (excluding celebratory cigar use less than 4 times a year)? ☐ Daily ☐ Only on the weekends ☐ A few times a year ☐ I have not used tobacco or nicotine products in the last 12 months. ☐ I have never used tobacco or nicotine products.]	
[2]	[Weight (pounds)]	[Height (feet, inches)]
[3]	[In the past 2 years, for any condition (other than childbirth), have you been; a. Admitted to or confined in a hospital, nursing home, extended care or special treatment facility for greater than 3 days? ☐ Yes ☐ No b. Have you been diagnosed by a member of the medical profession with a terminal condition (terminal condition means a medical condition resulting from injury or illness that is reasonably expected to result in the drastically limited life span of the Insured within 12 months or less)? ☐ Yes ☐ No c. Do you require assistance with any of the following activities of daily living: walking, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? ☐ Yes ☐ No]	
[4]	[Within the past 5 years, have you:	

	a. Plead guilty to or been convicted of more than 4 moving violations? ☐ Yes ☐ No b. Plead guilty to or been convicted of driving under the influence more than once? ☐ Yes ☐ No c. Received or been advised by a medical professional to seek medical treatment or counseling to reduce consumption or been prescribed medication for alcohol or substance abuse? ☐ Yes ☐ No d. Plead guilty to or been convicted of a felony or have any currently pending charges? ☐ Yes ☐ No e. Been on probation or parole? ☐ Yes ☐ No]
[5]	[In the past 5 years, have you (a) received treatment by a member of the medical profession for, or (b) been diagnosed or been advised by a member of the medical profession to seek treatment for, or (c) consulted with a medical professional regarding: a. Dementia, schizophrenia, attempted suicide or have been hospitalized or missed more than 1 week of work as a result of anxiety, depression, or bipolar disorder? ☐ Yes ☐ No b. Cirrhosis, Hepatitis C, stroke, brain tumor, leukemia, or any cancer (other than non-metastatic basal cell carcinoma or squamous cell carcinoma)? ☐ Yes ☐ No c. Central Nervous Disorder, Amyotrophic Lateral Sclerosis (ALS), lupus, chronic kidney disease, respiratory disorder, heart, or circulatory disorder (other than high blood pressure)? (Answer NO if you ONLY have asthma or high blood pressure) ☐ Yes ☐ No d. Uncontrolled diabetes or diabetes related complications such as hypoglycemia, retinopathy, neuropathy, cerebrovascular or peripheral vascular disease? ☐ Yes ☐ No]
[6]	[Have you ever been diagnosed by a member of the medical profession with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No]
[7]	[In the past 5 years, have you been advised by a medical professional to have a medical procedure, including surgery, a diagnostic test, or medical treatment of any kind which has not been done or, if completed, the results of which are not yet known, (other than for routine screening purposes or screening related to HIV/AIDS)? ☐ Yes ☐ No]
[8]	[In the past 5 years, have you tested positive for COVID-19 or self-isolated based on advice of a medical professional? ☐ Yes ☐ No]

[Payment]

[Payor's Full name and billing address [if different from the Owner]]

[Payment Frequency (Check One)]

[☐ Annual] [☐ Semi-Annual] [☐ Quarterly] [☐ Monthly] [☐ Bi-Monthly] [☐ Bi-Weekly]

[Payment Method]

[☐ Pre-authorized check (EFT)]

[Bank name:]	[☐ Checking ☐ Saving]	[Bank routing number:]	[Bank account number:]

[☐ Pre-authorized credit card/debit card]

[☐ Visa ☐ MasterCard ☐ American Express ☐ Discover]	[Card number:]	[Expiration date:]	[CVV:]

[Backup Payment Method]

[I agree that if a withdrawal request or any charge against my first choice of payment method is not paid or honored upon presentation by the Company, the Company will automatically attempt a transaction using my second choice of payment method.]

[Payor's Full name and billing address [if different from the Owner]]

[☐ Pre-authorized check (EFT)]

[Bank name:]	[☐ Checking ☐ Saving]	[Bank routing number:]	[Bank account number:]

[☐ Pre-authorized credit card/debit card]

[☐ Visa ☐ MasterCard ☐ American Express ☐ Discover]	[Card number:]	[Expiration date:]	[CVV:]

]

[THE PAYOR

I authorize Lumico Life Insurance Company to charge my Premiums to my [checking/saving account][or] Credit card/Debit card]. This authorization is to remain in effect until I request cancellation.

Signature	**Date]**

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INSURED DECLARATION AND REPRESENTATION

By signing below, I agree I have read or been read the application, and all statements and answers as they pertain to me, and that these statements and answers are true and complete to the best of my knowledge and belief. I understand the statements and answers in the application are the basis for any policy issued by Lumico Life Insurance Company ("the Company"). No information about these statements and answers will be considered to have been given to the Company unless it is stated in this application. I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in the policy not being issued, being delayed, unprocessed or terminated.

I understand and agree that no sales representative has the Company's authority to accept risks or pass on insurability or make, void, waive, or change conditions or provisions of the application, policy or receipt. If prior to the issuance of the policy applied for there is a change in the health of a proposed insured that would require a change to the proposed insured's answers to any questions in this application, any amendments thereto, or to any supplemental applications, prior to the issuance of the policy herein applied for, I will notify the Company as soon as possible of the change. I understand and agree that the Company will have no liability until the policy based upon this application is issued, delivered and accepted by me and the first premium is paid in full while each proposed insured is alive. If all these conditions are not met, the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Insurance 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.

Signature	**Date**

Signed at: City State

OWNER DECLARATION (Complete only if Owner is different than the Proposed Insured)

I agree that the statements and answers provided within the entire application form are true, complete, and correct to the best of my knowledge and belief. I acknowledge Lumico Life Insurance Company has the right to information sufficient to establish my identity and a valid insurable interest in the [life][lives] of the proposed insured[s].

Signature	**Date**

Signed at: City State

AGENT'S STATEMENT

To the best of my knowledge and belief, the proposed insured ☐ does ☐ does not have any existing life insurance or annuity contract in force or applications pending insuring the proposed insured's life.

To the best of my knowledge and belief, the proposed insured ☐ does ☐ does not intend to replace, terminate or change existing insurance or annuities with this transaction.

If the proposed insured "does" intend to replace, terminate or change existing insurance or annuities with this transaction, complete any required replacement forms.

[If the proposed insured intends to replace, terminate or change existing insurance or annuities with this transaction I certify that: (a) the responses herein are accurate to the best of my knowledge ; (b) I have provided the applicant(s) copies of all sales materials used in my presentation; and (c) that following preprinted or electronically presented carrier approved materials were used in my presentation (please provide form number):

Form Number

]

Signature	Date

Signed at: City | State

[Signature	Date

Signed at: City | State]

[Signature	Date

Signed at: City | State]