



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]

Section 1: Proposed Insured's Personal Information

First name	[Middle name]	Last name	
Gender (Select one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy):	[Birth State & Country]	[Social Security Number]
Home address (street address, city, state, zip)			
Mailing address (street address, city, state, zip)			
E-mail address:	Phone number:		
[Driver's License Number:]	[State of Issue:]	[Family status (single, couple, single with child(ren), couple with child(ren))]	
[Occupation:]	[Are you a United States citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No; or do you have Permanent Resident (Green Card) status? <input type="checkbox"/> Yes <input type="checkbox"/> No]		

Section 2: Owner (Complete only if Owner is different than the Proposed Insured)

First name	[Middle name]	Last name	
Relationship to Insured	[Social Security Number]		
Home address (street address, city, state, zip)			
Mailing address (street address, city, state, zip)			
E-mail address	Phone number:		

Section 3: Coverage

Type <input type="checkbox"/> 10 year level term <input type="checkbox"/> 15 year level term <input type="checkbox"/> 20 year level term <input type="checkbox"/> 30 year level term]	Coverage Amount \$	Riders <input type="checkbox"/> Dependent Child <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Waiver of Premium]
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Initial Payment Amount
\$

[Dependent Child Rider

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

Section 4: Other Coverage

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

☐ Yes ☐ No

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 or change any of life insurance policies or annuity contract you have? ☐ Yes ☐ No

If YES, please provide details:

Insurance Company Name	Type of Policy	Policy Number	Amount

Section 5: Beneficiary Information

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

Section 7: Payment Options

Full name and billing address [(if different from the Owner)]

Payment Frequency (Check One)

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

[CW:]

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

INSURED DECLARATION AND REPRESENTATION

By signing below, I agree I have 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 the 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].

I have received and read the Consent to Electronic Signature and Electronic Document Delivery.

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 or change existing insurance or annuities with this transaction.

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

Signature**Date***Signed at:*

City

State

[Signature**Date***Signed at:*

City

State

Signature**Date***Signed at:*

City

State]