Application for Individual Term Life Insurance **Gerber Life Insurance Company [1311 Mamaroneck Ave, White Plains, NY 10605]** **Must be 18 or older to qualify**

Select Amount: [❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $125,000 ❑ $150,000]

Select Duration:[❑ 10-Year Term ❑ 15-Year Term ❑ 20-Year Term ❑ 30-Year Term]

Full Name _____ _____ _____ Date of Birth _____
(Last) (First) (Middle Initial) (Month Day Year)

Address_____City _____State_____Zip_____

Email _____ Home Phone ( )_____Work Phone ( )_____

Sex_____ Age_____ Height___ft.___in. Weight_____ Are you a U.S. Citizen or a permanent legal resident of the U.S.? ☐ **Yes** ☐ **No**

Occupation _____ Employer_____

OWNERSHIP INFORMATION: (Complete this section only if the policy will be owned by someone other than the insured listed above.)

Full Name _____ _____ _____ Relationship to Insured _____
(Last) (First) (Middle Initial)

Address_____City _____State_____Zip_____

Email _____ Phone ( )_____

BENEFICIARY: Please print the name of your beneficiary here:

Name: Relationship:

1) In the past 12 months, have you smoked or used tobacco in any form? ☐ **Yes** ☐ **No**

2) Within the past 5 years, have you: been convicted of a felony; had a driver's license suspended or revoked; plead guilty to or been convicted of 2 or more moving violations; or currently on probation or parole? ☐ **Yes** ☐ **No**

3) In the past 5 years, have you: been hospitalized or consulted with or examined or treated by any doctor or health facility (excluding normal pregnancy or childbirth)? ☐ **Yes** ☐ **No**

4) In the past 5 years, have you: been advised by a physician to reduce the use of alcohol or to seek treatment for the use of alcohol or drugs; or used any controlled substance except as prescribed by a physician? ☐ **Yes** ☐ **No**

5) In the past 10 years, have you been treated or diagnosed by a physician for any of the following: Heart disease or disorder; cancer or tumor; diabetes; drug or alcohol abuse; AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex); high blood pressure or stroke; mental or nervous disorder; or any disorder of the blood, kidneys, liver, lungs, stomach, intestines or central nervous system; HIV (Human Immunodeficiency Virus) infection; pneumonia; or swollen lymph nodes? ☐ **Yes** ☐ **No**

Give full details if you answered "Yes" to any question above and list each condition. Use supplemental page if necessary.

Nature of Condition	Dates & Duration	Name & Address of Doctor & Hospital

Do you have an existing life insurance or annuity contract? ☐ **Yes** ☐ **No**
If yes, please complete the information below. A notice regarding replacement will be provided.

Company Name	Amount	Policy #	Year Issued	Will this be replaced?
				☐ **Yes** ☐ **No**
				☐ **Yes** ☐ **No**
Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application?				☐ **Yes** ☐ **No**

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

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.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character, and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). In addition, I authorize the MIB Inc. (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of the MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

X **Applicant's Signature** _____ **City/State**_____ **Date**_____