APPLICATION FOR {TruStage} INDIVIDUAL TERM LIFE INSURANCE

{OFFICE USE ONLY: 02}

Please print in black ink:

CMFG Life Insurance Company {• 2000 Heritage Way • Waverly, IA 50677}

{APPLICANT} COVERAGE AMOUNT AND TERM DESIRED:

{I wish to apply for the term coverage amount {below}:}

{☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ Other_____}

{{Check} {Term Desired}} { ☐ 10 Year ☐ 20 Year ☐ 15 Year ☐ 30 Year }

{☐}{__ {Optional} Waiver of Premium Rider{*} }

{APPLICANT INFORMATION:}

Name _____
{(First, Middle, Last)}

Address _____

City _____ State ____ Zip _____

Date of Birth ____ ____ ____ Birth State _____
{Month Day Year}

Social Security No. ___-___-____

Driver's License No. _____ State of Issuance ____

Are you a US Citizen? ☐ Yes ☐ No Gender ☐ Male ☐ Female

{Primary Phone (___) ___-____
{Best time to call ☐ am ☐ pm}}

{Secondary Phone (___) ___-____
{Best time to call ☐ am ☐ pm}}

{Email _____}

Occupation _____ Annual Income $ _____

Height _____ ft. _____ in. Weight _____ lbs.

{Your} Physician or Clinic (if none, write "none")

_____ City _____ State _____

BENEFICIARY INFORMATION:

Beneficiary Name _____
{(First, Middle, Last)}

{Address _____

City _____ State _____ Zip _____}

Relationship to {You} _____

{(For additional beneficiaries, please include a separate sheet with corresponding information, then sign and date.)}

Proposed Rate Classification: {For Home Office Use}

☐ Standard Non-Tobacco (N)
☐ Standard Tobacco (S)
☐ Preferred Plus Non-Tobacco (A)
☐ Preferred Non-Tobacco (P)
☐ Standard Plus Non-Tobacco (R)
☐ Standard Plus Tobacco (T)

Rate classes A, P, R and T are only available with face amounts of $200,000 or greater.

Table _____ Flat Extra _____

OWNER: {Complete only if different from {applicant}.}

{Please enter corresponding owner information identified in **a**, **b,** or **c** {below}.}

Name _____
{(First, Middle, Last)}

Address _____

City _____ State ____ Zip _____

Social Security No. or Employer Identification No. (EIN) _____

{Primary Phone (___) ___-____
{Best time to call ☐ am ☐ pm}}

{For identifying the owner, please complete section **a**, **b,** or **c** {below}.}

a. {Complete {below} if the owner is an} Individual

Date of Birth ____ ____ ____ {Month Day Year}

Are you a US Citizen? ☐ Yes ☐ No

Relationship to {Applicant} _____

b. {{Check} if the owner is a} Corporation or Business ☐

c. {{Check} if the owner is a} Trust ☐

{If valid trust (under state law), estate or pension trust, give name of trust and EIN of the legal entity; otherwise, name of grantor-trustee and their Social Security Number.}

PLEASE ANSWER THESE QUESTIONS FOR THE {APPLICANT}:

☐ Yes ☐ No {1.} Have you, in the last 5 years, had a driver's license suspended or revoked or been convicted of any moving violation or been involved in any accident in which you were found to be at fault?

☐ Yes ☐ No {2.} Have you ever been convicted of a felony or misdemeanor or have any such charge currently pending?

☐ Yes ☐ No {3.} Do you plan to travel or reside outside of the US or Canada within the next 2 years?

☐ Yes ☐ No {4.} Are you involved in non-commercial flights as a pilot or crew member, ballooning, hang gliding, sky/scuba diving, vehicle racing or mountain climbing? {If yes, include appropriate form(s).}

☐ Yes ☐ No {5.} Have you ever had any insurance declined, postponed, altered or offered at a higher than standard premium?

☐ Yes ☐ No {6.} Have you used any form of tobacco, including nicotine substitutes, in the last 12 months?

☐ Yes ☐ No {7.} Have you used any form of tobacco, including nicotine substitutes, in the last 24 months?

☐ Yes ☐ No {8.} Have you used any form of tobacco, including nicotine substitutes, in the last 36 months?

{• • • • • CONTINUED ON NEXT PAGE • • • • • •}

PLEASE ANSWER THESE QUESTIONS FOR THE {APPLICANT}:

☐ Yes ☐ No {9.} Have you ever used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a member of the medical profession?

☐ Yes ☐ No {10.} Have you received counseling or medical treatment for, or been advised by a member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs?

{11.} Have you ever been treated or diagnosed by a member of the medical profession as having {If yes, please indicate { ✔ } the condition(s)}:

☐ Yes ☐ No {a.} {❑}diabetes; {❑} high blood pressure; {❑} cancer; {❑} heart condition; {❑} lupus; {❑} paralysis or stroke; or disorders related to: {❑} intestines; {❑} breathing; {❑} blood; {❑} seizures; {❑} mental or nervous system; {❑} muscles; {❑} liver; or {❑} kidney?

☐ Yes ☐ No {b.} {❑} Acquired Immune Deficiency Syndrome (AIDS), {❑} AIDS-Related Complex (ARC), {❑} or tested positive for Human Immunodeficiency Virus (AIDS virus)?

☐ Yes ☐ No {12.} During the last 5 years, have you been examined, received treatment or been advised to seek treatment by a member of the medical profession{, other than indicated {above}}? (You may omit treatment for minor injuries or illnesses (such as colds) which prevent normal activities for less than 5 days.)

☐ Yes ☐ No {13.} Are you currently unable to work or attend school because of any illness or injury?

Give dates and details below for any "Yes" answers to questions {1-12} {above}. If more space is needed, attach a signed & dated separate sheet.

Question Number	Details or Reasons	Dates Began	Dates Ended	Details of Treatment or Follow-Up	Name & Address of Medical Professional, Clinic or Hospital

REPLACEMENT QUESTIONS:

☐ Yes ☐ No {1.} Do you have any existing life insurance policies or annuity contracts with our company or any other company?
(If yes, please list below. Use additional sheet if necessary then, sign and date.)

Name of Company & Policy Number	Coverage Amount	Coverage Type

☐ Yes ☐ No {2.} Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company?
(If yes, please list below. Use additional sheet if necessary then, sign and date.)

Name of Company & Policy Number	Coverage Amount	Coverage Type

TEMPORARY INSURANCE ELIGIBILITY QUESTIONS AND AGREEMENT

The temporary insurance agreement provides a limited amount of life insurance on the {applicant} for a limited time while we consider the application for approval. Coverage provided under this agreement does not apply to any rider providing waiver of premium. Additionally, if either question {below} is answered yes or left blank, no agent of CMFG Life Insurance Company (Company) is authorized to accept money and no coverage will take effect under the temporary insurance agreement.

☐ Yes ☐ No {1.} Within the last 12 months, received, sought or had recommended any treatment for: cancer; stroke; any disease of the heart; any disease of the liver; any disease of the immune system; or alcohol/drug use?

☐ Yes ☐ No {2.} Have you been advised to be hospitalized or are you currently a patient in a hospital or medical facility at the time of this application?

This temporary coverage amount is limited to the amount of coverage applied for up to a maximum benefit of $500,000.

Coverage begins under this agreement when we receive the full first premium required by the company.

Coverage ends automatically under this agreement on the earliest of the following: 1) when coverage starts under the policy applied for; 2) when we offer coverage other than as applied for; 3) when we mail notice to the owner of our decision to decline the application or terminate coverage under this agreement; 4) when you request cancellation; or 5) 60 days after the date of the application.

Coverage exclusions. No coverage will take effect under this agreement if: 1) the {applicant} commits suicide; 2) the application contains material misrepresentation or is fraudulently completed; or 3) payment of premium is not honored for payment when first presented or the company is unable to collect the first premium payment due to incomplete or incorrect payment information.

{REMARKS}

{ • • • • • • CONTINUED ON NEXT PAGE, SIGN AND DATE • • • • • • }

{AUTOMATIC PAYMENT AUTHORIZATION: }

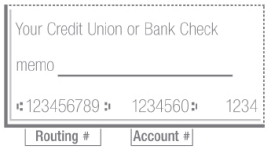
[I understand that selecting automatic payments allows me to get the lowest rate, as shown in this mailing.]

{Premium payment frequency:} [❑] [__] {Monthly} [❑] [__] {Quarterly} [❑] [__] {Semi-annual} [❑] [__] {Annual} [❑] [__] {Other _____}
{Premium payment {mode}:}

[❑] [__] [Other]] [Financial Institution] [Checking] [Account] {(Routing# [__ __ __ __ __ __ __ __ __] [(must be 9 digits)] [(9 digits)]. Acct#_____)}

[❑] [__] {{Electronic Funds Transfer {(ACH)}} {(Routing# [__ __ __ __ __ __ __ __ __] [(must be 9 digits)] [(9 digits)]. Acct#_____)}

[[❑] [__] [Please] [Send me a bill.] [Bill me.] [Monthly direct bill is not available.]



I authorize CMFG Life Insurance Company to deduct [monthly] premiums from the account I've selected for the life coverage[(s)] applied for on this application. This authorization remains in effect until revoked by me in writing or by phone.

[Deductions will be determined by the policy effective date] [unless another date is selected] [.] [Please deduct my payment on the ___ of each month.] [Circle the day of the month you prefer for account deductions: **1 5 10 15 20 25 Other Day** _____]

[Note: Allow 2 business days from the above selected date for deductions to occur.] [**The first deduction may not be deducted on the day of the month you selected.]** [You will be notified in writing before the first deduction occurs.]

[If you leave this section blank] [If you do not choose an option], [we will bill you] [you will receive a bill][.]

{Account Holder's} Signature **Date Signed**
{(Sign only if other than {applicant})}

AGREEMENT/AUTHORIZATION:

All my statements and answers are true to the best of my knowledge and belief. This application and any supplemental application(s) will be the basis of any insurance issued. {Except as stated in the Temporary Insurance Agreement,} I understand that this insurance becomes effective only if: 1) my application is approved and a policy issued; 2) my first full payment is received while I am alive; and 3) the answers to questions concerning my insurability are as stated in this application. {My agreement in writing is required for entries made by the Company in the Home Office Use Only section as to age, plan, riders, amount, benefits or rate class.} {Agents are not authorized to determine insurability, void, waive or change any terms of the application, or make a contract for the Company.}

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc. (MIB), consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status, or other relevant information about me to give all information (except psychiatric treatment notes) to the Company or its reinsurers to determine eligibility for insurance or benefits. Information obtained will be shared only on an as needed basis with reinsurers, MIB, and individuals within the Company or contracted by the Company related to the application and subsequent insurance-related functions such as underwriting and claims, as permitted or required by law, or as I further authorize. The health information shared for these purposes is not subject to federal health information privacy laws; however state privacy laws do apply. I authorize the Company, or its reinsurers, to make a brief report of my personal information to MIB.

I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For the purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits. The Important Notice to Applicants for Insurance has been received by me.

{If a corporation, business, or individual other than the {applicant} is named as owner in the owner section. I, the {applicant}, hereby consent to this coverage. I understand I have no rights of ownership to the policy, including the right to name a beneficiary.}

{I hereby acknowledge receipt of the Summary and Disclosure Notice for the Accelerated Benefit Option Endorsement.}

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

{DATE, SIGN AND RETURN:}

{Applicant's} Signature **Date Signed**
{(If age 16 and over; otherwise, Parent or Guardian)}

City/State Signed

Owner's Signature {(sign only if different than {applicant})} **Date Signed**

CONTINUED ON NEXT PAGE

AGENT QUESTIONS **{AGENT USE ONLY}**

☐ Yes ☐ No 1. Does the {applicant} have any existing life insurance or annuities with our company or any other company?

☐ Yes ☐ No 2. Will this policy replace, discontinue, or change any existing life insurance or annuities?

If yes, I hereby confirm:

3. This replacement meets the standards identified in CMFG Life's Statement Regarding the Acceptability of Life and Annuity Replacements Sales.
4. The following sales material was used: _____
   4a. If no sales material used, check here ☐
5. Reason(s) for replacement: _____

{Credit Union/Organization ID _____ Credit Union/Organization Name _____}

Agent's Signature **Date Signed** **Agent No.**

{HOME OFFICE USE ONLY}