[MARKETING PARTNER]

[Life Insurance Program]

[Underwritten By:]
AMERICAN FAMILY LIFE INSURANCE COMPANY
[Life Direct]
[6000 American Pkwy Madison, WI 53783]

Tel: [1-877-536-2373]

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

PROPOSED INSURED/OWNER			
First Name	Middle	Last Name	Suffix
Street Address			
City/Town		State	Zip
Mailing Address			
City/Town		State	Zip

Birth Date	Social Security #	Gender ☐ M ☐ F	Any previous name(s)

Email Address	Telephone #

Driver's License #	Issue State	Expiration Date

Birthplace (Country)	Birthplace (State)

U.S. Citizen ☐Yes ☐No	If not a U.S. Citizen: Permanent Resident ☐Yes ☐No Alien Registration Number:

PRODUCT INFORMATION	
Plan	Amount of Insurance

OTHER INSURANCE

Are there any life insurance policies or annuity contracts in force on your life? ☐Yes ☐No
Will the policy applied for replace, discontinue or change any life insurance policy or annuity contract? ☐Yes ☐No
If yes, provide details:

Insurer	Policy #	Face Amount	Year Issued

UNDERWRITING QUESTIONS

1. What is your current: height: ____ft. ____in. and weight: ____lbs.

2. Have you ever used nicotine? ☐Yes ☐No

3. In the past 7 years have you been treated for, diagnosed with, tested positive for, or been given advice by a medical professional for:
   a. any diseases or disorders of the heart (including rheumatic fever), circulatory system, or blood; high blood pressure; or elevated cholesterol ☐Yes ☐No
   b. stroke or TIA (transient ischemic attack) ☐Yes ☐No
   c. any diseases or disorders of the kidneys, liver, digestive system, or lungs (including allergies or sleep apnea) ☐Yes ☐No
   d. diabetes; endocrine or thyroid disease ☐Yes ☐No
   e. any mental or nervous disorders, including depression or anxiety ☐Yes ☐No
   f. cancer ☐Yes ☐No
   g. arthritis; muscular, spinal, joint, or bone disorders or injuries, including concussions ☐Yes ☐No
   h. epilepsy/seizures, including dizziness or fainting ☐Yes ☐No
   i. congenital defects or physical impairments ☐Yes ☐No

4. In the past 12 months have you been advised by a medical professional to have any evaluation, diagnostic testing or treatment that has not been completed, except diagnostic tests related to the Human Immunodeficiency Virus (HIV)? ☐Yes ☐No

5. Have you ever tested positive for or been diagnosed by a member of the medical profession as having Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or any immune deficiency disorder? ☐Yes ☐No

6. In the past 5 years have you:
   a. used marijuana, narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or used other non-prescribed or illegal drugs? ☐Yes ☐No
   b. received medical treatment or counseling for, or been advised by a medical professional to discontinue, the use of alcohol or prescribed or non-prescribed or illegal drugs? ☐Yes ☐No

7. In the past 10 years, have you been convicted of or pled guilty or no contest to a felony offense, or are felony charges currently outstanding against you? ☐Yes ☐No

8. During the next 2 years, do you plan to travel or reside outside the United States, including for military deployment? ☐Yes ☐No

9. In the past 3 years have you participated in, or in the next 2 years do you plan to participate in:
   a. aeronautics including hang gliding, sky diving, parachuting, BASE jumping, soaring, wingsuiting, ultralighting or ballooning ☐Yes ☐No
   b. SCUBA or skin diving ☐Yes ☐No
   c. racing including car, truck, motorcycle or boat racing ☐Yes ☐No
   d. climbing including mountain and rock climbing ☐Yes ☐No

10. In the past 3 years have you, or in the next 2 years do you plan to: pilot an aircraft or fly other than as a passenger on a scheduled airline? ☐Yes ☐No

11. In the past 5 years have you pled guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug? ☐Yes ☐No

12. In the past 3 years have you had your driver's license suspended or revoked, or pled guilty to or been convicted of careless or reckless driving or had more than 3 driving violations? ☐Yes ☐No

13. Do the duties of your occupation include working at heights greater than 50 feet, working with explosives, underground mining or underwater exploration? ☐Yes ☐No

UNDERWRITING DETAILS
Provide details for any Underwriting Questions answered YES. Check all that apply.

BENEFICIARY				
Primary Beneficiary Name(s)	Date of Birth	Social Security #	Relationship to Insured	Percentage
Contingent Beneficiary Name(s)	Date of Birth	Social Security #	Relationship to Insured	Percentage

PAYMENT INFORMATION

Monthly Premium

I understand that premiums are due monthly and will be billed through an automatic recurring payment plan. Payment information will be collected separately and my account will only be charged if this application is approved.

NOTICES

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.

INSURANCE INFORMATION PRACTICES

We need to collect information about you in order to issue a life insurance policy. You are our most important source of information. We will also collect information from other sources. In certain circumstances, as permitted or required by law, this information may be disclosed to third parties without your authorization. You have the right to access and if necessary correct this information. We will send you a more detailed explanation of our information practices, including your right to access and correct information, if you send a written request to our administrative office:

[American Family Life Insurance Company]
[PO Box 5315, Binghamton, NY 13901-9812]

MIB, Inc. NOTICE

We or our reinsurers may make a brief report about your insurability to MIB, Inc. (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply that company with the information they have about you. We or our reinsurers may also release information in our files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction according to the procedures set forth in the Federal Fair Credit Reporting Act. You may contact the MIB's information office at:

MIB, Inc.
50 Braintree Hill Park
Suite 400
Braintree MA 02184-8734
866-692-6901 (TTY 866-346-3642)
infoline@MIB.com

AGREEMENT

By signing this application I understand and agree as follows:

1. All answers in this application are to the best of my knowledge and belief true and complete. American Family Life Insurance Company (AFLIC) will rely on the answers when making its decision to issue a policy.

2. This application will become part of the policy. Any false or incomplete answers may invalidate the policy.

3. The insurance applied for will become effective upon all of the following:
   a) the first premium is paid in full during my lifetime;
   b) any required amendments have been signed and returned to AFLIC's administrative office; and
   c) my health and insurability remains as described in this application.
   The first premium will not be deemed paid unless any draft, credit card payment or other instrument of payment given for premium is paid according to its terms.

4. I have read the notices regarding MIB, Inc., Insurance Information Practices, and the Insurance Fraud Warning.

5. I have full right and authority to sign this application.

SIGNATURE

State Where Signed	
[Agent's Signature]	[Date]
Proposed Insured's Signature	Date