TIAA

TIAA-CREF LIFE INSURANCE COMPANY
[**New Business Administrative Office:** P.O. Box 1291, Charlotte, NC 28201-1291]
[**Home Office:** 730 Third Avenue, New York, NY 10017-3206]

INDIVIDUAL LEVEL TERM LIFE INSURANCE APPLICATION – PART I

[This Application is for YOUR use.] Please Print in Black or Blue Ink

SECTION A: PROPOSED INSURED

Full Legal Name (Title, First, Middle, Last, Suffix): _____

Date of Birth: _____ / _____ / _____ (Month / Day / Year) Gender: ☐ Male ☐ Female Maiden Name: _____

Residence Address: _____ (Number/Street/Apt. No. / City / State / Zip)

Social Security No.: | | | | | | | | | |

U.S. Citizen: ☐ Yes ☐ No _____
(If no, please provide a Permanent Residency Card No. or U.S. Visa No. and Expiration Date.)

Birthplace: _____ (State (or Country if outside the U.S.)) Driver's License No.: _____ State of Issue: _____

Primary Telephone Number: ( ) _____ Alternate Telephone Number: ( ) _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Civil Union

Annual Income: _____ Occupation: _____

SECTION B: PROPOSED OWNER INFORMATION (COMPLETE IF DIFFERENT FROM PROPOSED INSURED)

Full Legal Name: _____ Relationship to Proposed Insured: _____

Date of Birth: _____ Social Security No.: | | | | | | | | | |

Primary Telephone Number: ( ) _____

Residence Address: _____ (Number/Street/Apt. No. / City / State / Zip)

Email: _____

U.S. Citizen: ☐ Yes ☐ No _____
(If no, please provide a Permanent Residency Card No. or U.S. Visa No. and Expiration Date.)

SECTION C: POLICY INFORMATION

Coverage Amount: ☐ $100,000 (Minimum) ☐ $250,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ Other: $_____

Policy Type: ☐ 10-Year Level Term ☐ 15-Year Level Term ☐ 20-Year Level Term ☐ 30-Year Level Term

Optional Riders: ☐ Charitable Giving Benefit Rider (no additional cost) - not available in [KY, MD, or TN]
☐ Waiver of Premium Rider (additional cost)

Payment Method: ☐ EFT (Bank Draft) ☐ Credit Card ☐ Direct Bill

Payment Frequency: ☐ Monthly **(EFT Only)** ☐ Quarterly ☐ Semi-Annual ☐ Annual

SECTION D: EXISTING COVERAGE – POTENTIAL REPLACEMENT (TO BE COMPLETED BY THE OWNER OF THE PROPOSED POLICY)

1. Does the Proposed Insured have any existing individual life insurance or annuity contracts? If yes, complete the chart below. ☐ Yes ☐ No
2. Will any existing life insurance or annuity contract held by the Owner or Proposed Insured be replaced, changed, or used to pay for the insurance applied for in this application? If yes, complete the chart below. ☐ Yes ☐ No

Company Name	Owner Name	Insured Name	Policy Number	Year Issued	Face Amount	Replacing?
						☐ Yes ☐ No
						☐ Yes ☐ No

FPO [XXX] [TI IA]

SECTION E: HEALTH QUESTIONS (CIRCLE ALL CONDITIONS THAT APPLY - PROVIDE DETAILS TO **YES** ANSWERS BELOW)

In the past 10 years, has a licensed member of the medical profession provided you with any treatment, medical advice, consultation or follow-up for; or diagnosed you with: cancer, diabetes, stroke, paralysis or dementia; degenerative muscle or nerve disease/disorder; schizophrenia; **OR** any disease or disorder of the heart, aorta, coronary arteries, peripheral arteries, blood (excluding HIV), liver, pancreas, kidney (other than kidney stones) or brain?	☐ Yes ☐ No
Has a licensed member of the medical profession ever diagnosed you with, or advised you that you tested positive for, Human Immunodeficiency Virus (HIV) or diagnosed you with Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No

Details (if applicable):

SECTION F: BENEFICIARY INFORMATION

If you need more space to name your beneficiaries, please continue on a separate sheet of paper. Make sure to sign the additional page of instructions. The total of percentages in each beneficiary class must equal 100%.

Full Legal Name of Beneficiary or Trust and Trustee(s)	Address (incl. Country of Residence) and Telephone Number	Relationship to Insured	Benefit % (Whole Numbers Only)	Date of Birth or Date of Trust	Social Security or Tax ID No.	Primary (P) or Contingent (C)
						☐ P ☐ C
						☐ P ☐ C

SECTION G: APPLICATION ACKNOWLEDGEMENT AUTHORIZATION

CUSTOMER IDENTIFICATION NOTICE

Federal law requires that insurance companies obtain and retain relevant and appropriate customer-related information necessary to administer an effective Anti-Money laundering program. This means we will ask you for your name, residential address (not a P.O. Box), date of birth, Social Security Number and other information as appropriate (e.g. Driver's license, utility bills to verify address, social security card, etc.).

I, the Proposed Owner, acknowledge receipt of the Customer Identification Notice. I understand that the identity information being provided by me is collected to verify my identity as required and I **authorize** its use for this purpose.

I agree that I have read the application. The statements and answers made in this application are true and complete to the best of my knowledge and belief and are made to obtain the insurance applied for. **These answers, together with those provided in Part II of the application, if any, and any additional supplements, will be attached to and made a part of the issued policy.** No information will be considered to have been given to TIAA-CREF Life Insurance Company ([TIAA Life]) unless it is stated in the application. I will notify [TIAA Life] of any changes to the statements or answers given in the application between the time of the application and delivery of the policy. I understand that the insurance I applied for will take effect only if [TIAA Life] accepts this application and issues a policy and if, on the date of issue: (1) the first premium has been paid, (2) the Proposed Insured is alive, and (3) all conditions used to determine the Proposed Insured's insurability remain as stated in the application. No one except [TIAA Life]'s officers may make, change or discharge any insurance contract, or bind [TIAA Life] by making any promises about any policy benefits applied for.

I, the Proposed Insured, hereby **authorize** any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy, pharmacy benefit manager, insurance company or reinsurer, financial institution, government agency, MIB, Inc. (MIB), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of [TIAA Life], the following information pertaining to me: (1) employment information; (2) other insurance coverage, claims and records; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics. I understand and agree that [TIAA Life] may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits and that [TIAA Life] may disclose all or some of my information to its reinsurers, its agents, and the business process organizations (BPO) which administer various underwriting, new business, policyholder service and claims adjudication functions on its behalf. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. I **authorize** [TIAA Life] or its reinsurers to make a brief report of my personal health information to MIB. This authorization is valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, but it shall not exceed two years. A photographic copy of this authorization is as valid as the original, and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request for revocation to [TIAA Life] in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause [TIAA Life] to reject my application.

A sales representative does not have [TIAA Life]'s authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application or policy, as appropriate.

Any person who knowingly presents a false statement in an application of insurance may be guilty of a criminal offense and subject to penalties under state law.

X _____ _____

Signature of Proposed Insured | Signed at (City, State) | Date

X _____ _____

Signature of Proposed Owner (only if different from Proposed Insured) | Signed at (City, State) | Date