[POLICYHOLDER OR UNION LOGO]]

INDIVIDUAL LIFE INSURANCE APPLICATION
THE UNION LABOR LIFE INSURANCE COMPANY
[Administrative Office: P.O. Box 9159, Phoenix, AZ 85068]
[Home Office: 8403 Colesville Road, Silver Spring, MD 20910]
[Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006]

[John Q. Sample
Street Road
Second Address Line
Anytown, US 00000]

[Member of: International Union Personalized]

1. Please tell us about yourself: [Please print in [black] ink.]

[Proposed Insured Name: [John Doe]
Address 1 [123 ABC Lane]
Address 2 [Unit 7654]
City, State, Zip [Capris, IA 73259]]

Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR

Gender [at birth]: ☐Male ☐ Female

[Height: ☐☐ Weight: ☐☐
FT IN LBS]

[State/Province [or Country] of Birth _____]

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE
Best time to call: [☐ Morning ☐ Afternoon ☐ Evening]

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐
E-Mail Address_____
[If] you share your e-mail address, you may receive periodic promotional offers from Union Labor Life. You will always have the right to opt-out of receiving these e-mails.

If Owner is different from the Proposed Insured, please answer:

Owner Name: [Jane Doe]
Address 1 [123 ABC Lane]
Address 2 [Unit 7654]
City, State, Zip [Capris, IA 31529]

Date of Birth
☐☐■☐☐■☐☐☐☐
MONTH DAY YEAR

Your relationship to Proposed Insured:_____

Phone ☐☐☐■☐☐☐■☐☐☐☐
AREA CODE

Best time to call: [☐ Morning ☐ Afternoon ☐ Evening]

Social Security # ☐☐☐■☐☐■☐☐☐☐
Driver's License# _____ State of Issue ☐☐
E-Mail Address_____
[If] you share your e-mail address, you may receive periodic promotional offers from Union Labor Life. You will always have the right to opt-out of receiving these e-mails.

2. Please select the benefits that you would like:

[[Choose One] Product [Below:]]
[☐ 10 Year Term ☐ 15 Year Term
☐ 20 Year Term ☐ 25 Year Term ☐ Other _____]

[[Choose One] Coverage Amount [Below:]]
[☐$250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000
☐$75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]

[Please check any additional provision or coverage that you would like:

[☐ Automatic Loan Provision: By checking this Automatic Loan Provision box, you will allow Union Labor Life to make premium payments for you. This special feature helps you avoid missing a premium payment (note: use of the Automatic Loan Provision also reduces the accumulated cash value and reduces the death benefit that is paid).]

[☐ Accidental Death Benefit Rider: Coverage Amount: ☐ $100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other _____]
[☐ Children's Term Life Insurance Benefit Rider: Coverage Amount: ☐ $10,000 ☐ $5,000 ☐ Other_____]
List child(ren)'s name(s) and date(s) of birth in the section below:
Name_____ Date of birth ☐☐☐
Name_____ Date of birth ☐☐☐]]

[Use a separate sheet of paper to list children and dates of birth if more space is needed. Please be sure to sign and date each sheet.]

[3. Please complete the beneficiary information for the Proposed Insured:

Beneficiary means the [Owner] who is designated to receive the insurance benefits. [Designation must equal 100%.]

☐ **Primary** [% Share ☐☐☐]
Your Beneficiary _____ Relationship to the Proposed Insured_____
Address_____
City, State, Zip_____
[Social Security Number ☐☐☐■☐☐■☐☐☐☐]

[☐ **Primary** [% Share ☐☐☐]
Your Beneficiary _____ Relationship to the Proposed Insured_____
Address_____
City, State, Zip_____
[Social Security Number ☐☐☐■☐☐■☐☐☐☐]]

[☐ **Contingent** [% Share ☐☐☐]
Your Beneficiary _____ Relationship to the Proposed Insured_____
Address_____
City, State, Zip_____
[Social Security Number ☐☐☐■☐☐■☐☐☐☐]]

[☐ **Contingent** [% Share ☐☐☐]
Your Beneficiary _____ Relationship to the Proposed Insured_____
Address_____
City, State, Zip_____
[Social Security Number ☐☐☐■☐☐■☐☐☐☐]]

[4. Please answer the following question(s) for the Proposed Insured:

1. Do you have existing life insurance or annuity contracts with Union Labor Life or any other company? ☐ Yes ☐ No

2. The current amount of total life insurance or annuity contracts I have or that I am applying for with other companies (not including any coverage through my employer) is _____.

3. Is this policy being purchased with the intent of assigning or selling it to a third party? ☐ Yes ☐ No

4. If approved, I plan to replace or change a current life insurance policy or annuity contract with my Union Labor Life insurance policy. ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please provide the details in the space below. Identify the question number, and include insurance company names, addresses and telephone numbers. Attach a separate sheet if needed. Please be sure to sign and date each additional sheet.

_____

_____

_____]

[5A]. Please answer the following question(s) for the Proposed Insured:	
MEDICAL QUESTIONS	
[1. Have you lost more than 15 lbs in the last 12 months?	☐Yes ☐ No]
2. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for : Alzheimer's disease, dementia, dizziness, fainting, convulsions, epilepsy, seizures, tremor, Parkinson's disease, migraines, paralysis, stroke, transient ischemic attack (TIA), memory loss, neuropathy, multiple sclerosis, organic brain syndrome, or other neurological disease?	☐Yes ☐ No
3. In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: a. shortness of breath, chronic cough, chronic bronchitis, chronic obstructive lung disease, emphysema, asthma, tuberculosis, sleep apnea, or other respiratory or lung disorder? b. anxiety, depression, chronic fatigue, suicidal thoughts, or any other psychiatric, emotional, behavioral, schizophrenia, bipolar or mental or nervous disorder	☐Yes ☐ No ☐Yes ☐ No
4. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐Yes ☐ No
5. In the past 10 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for malignant melanoma, lymphoma, leukemia, or other cancer (excluding basal and squamous cell skin cancer)?	☐Yes ☐ No
6. In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: a. any disease or disorder of the heart, circulatory system or blood vessels, high blood pressure, chest pain, rapid heart rate, palpitations, heart murmur, heart attack, rheumatic fever, aneurysm, or coronary artery disease? b. kidney or renal insufficiency or failure, recurring protein or blood in the urine or other kidney or bladder disorder? c. diabetes, high blood sugar, thyroid disorder, or disorder of the adrenal, pituitary or parathyroid gland? [d. ulcer, stomach or intestinal bleeding, jaundice, hepatitis, colitis, Crohn's disease, chronic diarrhea, or other disorder of the stomach, intestines, liver, or pancreas? [e. rheumatoid arthritis, chronic pain, systemic lupus, fibromyalgia, or other connective tissue disorder?	☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No] ☐Yes ☐ No]
[7. In the past 10 years, have you used alcohol or other drugs to the degree that required treatment or advice from a physician or other licensed practitioner?	☐Yes ☐ No]
[8. In the last 5 years, have you been declined, postponed, or charged an extra premium for life insurance?	☐Yes ☐ No]
[9. Within the last 12 months, have you used a nicotine-based product in any form including electronic cigarettes?	☐Yes ☐ No]
[10. Have you had any immediate family members (parent, brother or sister) diagnosed by a member of the medical profession with or die prior to age 60 from heart disease, diabetes, cancer, polycystic kidney disease, or other familial disease?	☐Yes ☐ No]]

[If you answered "Yes" to [any of] the above question[s], please provide as much detail as possible in the space below. [Identify the question number, and] [I]nclude diagnoses, dates, durations, names, addresses and phone numbers of all attending physicians and medical facilities. [Attach a separate sheet if needed. Please sign and date each additional sheet.]

[5B]. Please answer the following question(s) for the Proposed Insured:		
NON-MEDICAL QUESTIONS		
[1. Are you an active member of the military, national guard, or reserves?	☐Yes ☐ No]	
[2. In the past 10 years, have you been found guilty of or convicted of a felony or misdemeanor, are you currently incarcerated, or are there any criminal charges pending or on parole or probation?	☐Yes ☐ No]	

[3. In the past 5 years, have you had your driver's license suspended, plead guilty to or been convicted of reckless driving, driving under the influence of drugs or alcohol, or been convicted of more than 2 moving violations?	☐ Yes ☐ No]	
[4. In the past 2 years, have you flown an aircraft as a pilot or student pilot or intend to do so in the next 2 years?	☐ Yes ☐ No]	
[5. In the past 2 years, have you engaged in any hazardous activity or sport such as hang gliding, hot air ballooning, ultra-light flying, mountain or rock climbing, motor vehicle or boat racing, or scuba or sky diving?	☐ Yes ☐ No]	
[6. In the past 5 years, have you declared bankruptcy?	☐ Yes ☐ No]	
	☐ Yes ☐ No]]	

[If you answered "Yes" to [any of] the above question[s], please provide as much detail as possible in the space below. [Identify the question number.] [Attach a separate sheet if needed. Please sign and date each additional sheet.]]

_____

_____

_____

[6.] Read, Sign and Date below.

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. I agree that this application will be the basis for, and will become part of, the policy that is issued. I understand that the statements and answers in the application are the basis for any policy issued by the company and that no information about me will be considered given unless stated in the application. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by The Union Labor Life Insurance Company ("the Company") and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's Incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. [I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.] I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice.

The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company.

I understand that state insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued, and that I should consult with legal advisors if I have any questions about these matters.

Authorization

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc. ("MIB"), pharmacy benefit manager, pharmacy, insurance laboratory, a consumer reporting agency, a Department of Motor Vehicles, my employer, or any other person or organization that has any record of information about me to give The Union Labor Life Insurance Company, its reinsurers information about me or my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information The Union Labor Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of The Union Labor Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its administrative office address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed. The time limit of this authorization shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that the information disclosed pursuant to this Authorization may be subject to redisclosure and no

longer protected by the privacy regulations under the Health Insurance Portability and Accountability Act. I further understand that if I refuse to sign this authorization, The Union Labor Life Insurance Company may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments.

FRAUD NOTICE:
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

Information Practices Notice

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in Our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer at the [Home] Office address.

Information Regarding the MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. I authorize The Union Labor Life Insurance Company or its reinsurers to make a brief report of my protected health information to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Union Labor Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at http://www.mib.com.

PAYMENT AUTHORIZATION - SELECT HOW YOU WANT TO PAY BELOW (you will be charged or billed later).
Choose ONLY one option.

- ○ **[Monthly Electronic Funds Transfer EFT (**Attach a check marked "VOID" or provide your bank account information below.)
  Routing Number: ☐☐☐☐☐☐☐☐☐ Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐]
- ○ **[Monthly Credit Card Charge:** ☐ MasterCard ☐ Visa ☐ Discover
  ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ **Expiration Date:** ☐☐ / ☐☐☐☐ **]**
- ○ **[Quarterly. Please bill me directly**.]

I hereby authorize The Union Labor Life Insurance Company to initiate debit entries to the Bank Account or Credit Card indicated above. I acknowledge and understand my payment will be processed [between the [1st and 28th] of the month] when the payment is due and my account will be charged only after coverage is issued. This authorization is to remain in force until The Union Labor Life Insurance Company has received written notification from me of its termination

[X_____
Proposed Insured Signature **Date**

[X_____
[eSignature]

[Signed at _____
City, State]

X_____
Owner Signature **Date**
(If different from Proposed Insured)

[
X_____
[eSignature]

[Signed at _____

	City, State]

[Agent/Producer Certification]

I certify that: (1) the application was obtained personally [and in my presence]; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; [and] (3) to the best of my knowledge, this policy will ☐ will not ☐ replace or change any existing life insurance or annuity policy(ies)[.] [; and (4) I have witnessed the signature(s) on this application].

_____	_____	_____
Licensed Agent's/Producer's Signature	Agent's/Producer's Printed Name	Agent's Producer Number

_____	_____
Telephone Number	E-mail Address

_____	_____
License #	State

_____
Date

Mail Policy To: ☐ Owner ☐ Agent]