Liberty Life Assurance Company of Boston
Service Center, [100 Liberty Way, Dover, NH 03820]

[Contract number _____ (Home office use only)]

Application for Individual Life Insurance

[1.] PROPOSED INSURED

Name (First, Middle, Last) _____ ☐ Male ☐ Female

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Birth date _____ [☐ Backdate to save age] Birthplace (State, Country) _____

Driver License number _____ Issue state _____ Expiration date _____

Social Security number _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____

[Employer name _____] [Employer telephone number _____]

[Employer address (Street, City, State, ZIP) _____]

Occupation (Include duties) _____

Annual earned income $_____ Other income (Include source) $_____ [Net worth $_____]

[2.] QUALIFYING INFORMATION

[Provide complete details to all "Yes" answers in the Details section below.]

I[(We)] declare that all of the following disclosures and answers I[(We)] provide in this application are true and complete to the best of my[(our)] knowledge and belief. ☐ Yes ☐ No

a) Proposed insured Height (ft, in) _____ Weight (lbs) _____

Has the proposed insured:	**Yes**	**No**
b) within the past 12 months, used any form of tobacco or nicotine products?	☐	☐
c) within the past 12 months, collected or applied for disability or workers compensation benefits?	☐	☐
d) within the past 5 years, had a license suspended or revoked or been convicted of reckless driving or driving under the influence of alcohol or drugs (DUI) or driving with a suspended license?	☐	☐
e) within the past 5 years, used or been convicted of using illegal drugs, or used prescription drugs other than directed?	☐	☐
f) within the past 5 years, been convicted of a felony, been on probation, or been on parole?	☐	☐
g) had any immediate biological family members that have ever been diagnosed by a member of the medical profession with, or died because of, Cancer, Heart disease, Diabetes, Polycystic Kidney Disease, or Huntington's Disease?	☐	☐
h) [any current intention of traveling or residing outside the United States or Canada within the next two years? [(If "Yes," please complete Foreign Travel Questionnaire.)]]	☐	☐
i) in the last 6 months, been advised by a member of the medical profession to have any surgery, hospitalization, treatment or test that was not completed, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐
Has the proposed insured within the past 3 years, engaged in or does the proposed insured plan to engage within the next 2 years:		
j) in motor sports (land or water), mountain climbing, rock climbing, skydiving, parachuting, hang gliding, or scuba diving? [(If "Yes," please complete Hazardous Sports Questionnaire.)]	☐	☐
k) in flying as a pilot, or student pilot? [(If "Yes," please complete Aviation Questionnaire.)]	☐	☐

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[2.] QUALIFYING INFORMATION CONTINUED

[Provide complete details to all elected diseases or illnesses in the Details section below.]

Has the proposed insured been diagnosed with or treated within the past 10 years by a member of the medical profession for any of the following diseases or illnesses? [(If none apply, check "None")]

l) Check all that apply:
- ☐ Chest pain
- ☐ Heart attack
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular heartbeat/arrhythmia
- ☐ Congestive heart disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Mini-stroke/transient ischemic attack (TIA)
- ☐ Heart valve disease
- ☐ Aneurysm
- ☐ Peripheral vascular disease
- ☐ Carotid artery disease
- ☐ Any other disease of the heart or circulatory system
- ☐ None

m) Check all that apply:
- ☐ Cancer
- ☐ Tumor
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Melanoma
- ☐ None

n) Check all that apply:
- ☐ Emphysema
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Pulmonary embolism
- ☐ Any other disease of the respiratory system
- ☐ None

o) Check all that apply:
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Kidney disorder or failure
- ☐ Any other disorder of the digestive systems
- ☐ None

p) Check all that apply:
- ☐ Seizures
- ☐ Paralysis
- ☐ Muscular/neurological disorders
- ☐ Parkinson's disease
- ☐ Cerebral palsy
- ☐ Multiple sclerosis
- ☐ Alzheimer's disease
- ☐ Dementia
- ☐ Any other disease of the brain or nervous system
- ☐ None

q) Check all that apply:
- ☐ Lupus
- ☐ Connective tissue disorder
- ☐ Anemia
- ☐ Blood clots
- ☐ Infection with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Any other disease of blood or immune system?
- ☐ None

r) Check all that apply:
- ☐ Intellectual/cognitive disability
- ☐ Autism spectrum disorder
- ☐ Down syndrome
- ☐ None

s) Check all that apply:
- ☐ Major depression
- ☐ Attempted suicide
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Alcohol or drug dependency or abuse
- ☐ None

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[3.] DETAILS

[Provide details here to any qualifying information questions answered "Yes."]

[Question #/Insured name] [Additional Information]

[[4.] PHYSICIAN INFORMATION

[Please provide physician information for the proposed insured.]

[Physician name _____

Facility name _____ Telephone number _____

Mailing address _____

Date and reason last seen _____

Physician of (provide insured's name) _____

Physician name _____

Facility name _____ Telephone number _____

Mailing address _____

Date and reason last seen _____

Physician of (provide insured's name) _____

Physician name _____

Facility name _____ Telephone number _____

Mailing address _____

Date and reason last seen _____

Physician of (provide insured's name) _____]]

[Contract number _____
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[5.] PRODUCT SELECTION [Select one product.]

[Term

Select one ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year | Face amount $_____

Riders ☐ Children's Protection $_____ ☐ Accidental Death and Dismemberment $_____
☐ Disability Waiver of Premium

Universal Life

Select one ☐ Spirit Series Universal Life ☐ Spirit Series Performance Universal Life

Face amount $ _____ | Modal Planned Premium amount $_____ | Mode _____

Death Benefit Option – Available for Spirit Series Performance Universal Life only. Select one
☐ Option 1 ☐ Option 2 ☐ Option 3

Riders ☐ Children's Protection $_____ ☐ Accidental Death and Dismemberment $_____
(Complete Children's Protection section if elected)
☐ Disability Waiver of Monthly Deduction
☐ Disability Waiver of Specified Amount

Whole Life

Select one ☐ Whole Life ☐ Whole Life Paid up at age 65
☐ 20 Payment Whole Life ☐ Extra Value Whole Life _____%_____% | Face amount $_____

Contract Credits ☐ Paid-up Additions ☐ Accumulate at Interest ☐ One-Year Term
☐ Reduce Premiums ☐ Cash

Riders ☐ Children's Protection $_____ ☐ Disability Waiver of Premium
(Complete Children's Protection section if elected)
☐ Payor Disability and Death
☐ Guaranteed Insurability Option $_____ ☐ Accidental Death and Dismemberment $_____

Do you elect Automatic Premium Loan? ☐ Yes ☐ No]

[6.] OWNER [☐ Select if same as insured.]

Name (First, Middle, Last)[/Entity] _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth[/Trust] date _____

Social Security/Tax ID number _____ [Relationship to insured] _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____

[[7.] JOINT OWNER [Complete if applicable.]

[Name (First, Middle, Last)[/Entity] _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth[/Trust] date _____

Social Security/Tax ID number _____ [Relationship to insured] _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____]]

[8.] ALTERNATE ADDRESSEE [You may authorize an alternate addressee to receive past due premium notices. (Optional Section)]

Name (First, Middle, Last) _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

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[[9.] PAYOR [☐ Select if same as owner. ☐ Select if same as insured.]

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Social Security/Tax ID number _____ Relationship to insured _____

Please complete if payor rider is selected. (Payor rider is applicable for Whole Life products only.)

Birth date _____ Birthplace (State, Country) _____ ☐ Male ☐ Female

Height (ft, in) _____ Weight (lbs) _____ Driver License number _____]

[[10.] INITIAL PAYMENT [Select an initial payment mode.]

Premium payment $ _____

☐ One Time Electronic Funds Transfer (EFT) ☐ Credit Card ☐ 1035 Exchange
☐ Check ☐ Payroll Deduction ☐ Other _____

One-time EFT - Complete if one time EFT was elected for initial payment.

Bank account owner name _____ Bank name _____

Routing number _____ Bank account number _____

Credit Card - Complete if credit card was elected for initial payment.

Type of credit card

☐ MasterCard ☐ Discover

☐ Visa ☐ American Express

Name on credit card _____

Credit card number _____

Expiration date _____ CVV _____

☐ Select if billing address is same as [owner/insured] mailing address

Billing address (Street, City, State, ZIP) _____

Payroll Deduction - Complete if payroll deduction was elected for initial or subsequent payment.

Client name _____ Client number _____

Member group name _____ Employee account number _____]

[[11.] SUBSEQUENT PAYMENT [Select a subsequent payment mode.]

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT ☐Credit Card ☐ Payroll Deduction
☐ Other _____

Monthly EFT - ☐ Select if same as initial payment one time EFT information.

Bank account owner name _____ Bank name _____

Routing number _____ Bank account number _____

Payroll Deduction - Complete if payroll deduction was elected for initial or subsequent payment.

Client name _____ Client number _____

Member group name _____ Employee account number _____

Credit Card - Complete if credit card was elected for initial payment.

Type of credit card

☐ MasterCard ☐ Discover

☐ Visa ☐ American Express

Name on credit card _____

Credit card number _____

Expiration date _____ CVV _____

☐ Select if billing address is same as [owner/insured] mailing address

Billing address (Street, City, State, ZIP) _____]

[[12.] BENEFICIARIES

[All designated beneficiaries will be considered primary, sharing equally, unless otherwise indicated. Beneficiary percentages must total 100%.]

☐ Primary ☐ Contingent __________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent __________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent __________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

____________________]

[[13.] CHILDREN'S PROTECTION

[“Children” means all children, step-children, and legally adopted children of the Insured who have not reached their 18th birthday. Insurance will not be provided on any child until 15 days after birth.]
[Provide complete details to all “Yes” answers in the Details section below.]

	Yes	No
a) Has any child less than one year old, been born premature or diagnosed or treated by a member of the medical profession with any congenital abnormalities or medical diagnosis?	☐	☐
b) Has any child greater than one year old, been diagnosed or treated by a member of the medical profession with: any congenital disorders, heart disease, asthma or respiratory disease, mental disorders, cancer, or any other disease or impairment?	☐	☐

[Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country) __________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country) __________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country) __________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country) __________ Height (ft, in) ______ Weight (lbs) ______]]

[[14.] DETAILS

[Provide details here to any qualifying information questions answered “Yes.”]

[Question #/Insured name] ____________________

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____

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____________________]

[Contract number _____
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[15.] COVERAGE/REPLACEMENT

	Yes	No
a) Is there any life insurance or annuity applied for or in force, other than group insurance, for the proposed insured? [(If applicable, complete and submit replacement forms.)]	☐	☐
Total life insurance in force $_____ Total Accidental Death Benefit $_____		
b) Will this contract replace any existing life insurance or annuity in this or any other company?	☐	☐
[If "Yes," replaced policy type ☐ Life ☐ Annuity ☐ Select if Section 1035 exchange		
Company name _____ Contract number _____]		
c) Does the proposed owner intend to sell, or transfer ownership of a contract issued as a result of this application? [If "Yes" provide details below.]	☐	☐
d) Has the proposed owner entered into an agreement, or discussed any arrangement, for the sale or transfer of a contract issued as a result of this application? [If "Yes" provide details below.]	☐	☐

[Coverage/Replacement Details

Question # Details

]

[16.] DISCLOSURES AND SIGNATURES

[**LIBERTY'S LIVING BENEFIT DISCLOSURE ACKNOWLEDGMENT -** I acknowledge that Liberty's Living Benefit, an Accelerated Death Benefit, is available to the primary proposed insured under this contract for initial death benefits greater than or equal to $20,000, and I have read and received the disclosure pertaining to Liberty's Living Benefit.

☐ Check here to exclude Liberty's Living Benefit.]

[**AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER -** By signing this application, I authorize Liberty Life Assurance Company of Boston (the Company) to initiate a one-time or monthly withdrawal from the specified account of the financial institution indicated, for the purpose of meeting premium payment obligations. I understand: (1) No premium is considered paid until each debit is accepted by the financial institution. (2) Any debit not honored may be subject to a return fee from the financial institution. (3) For any debit not honored, the Company may attempt to debit the account again up to three days later for the amount due. (4) The Company will not incur liability as a result of a debit that is not honored by the financial institution. (5) The payor or the Company may terminate this agreement at any time by written notification from one party to the other party.]

[**AUTHORIZATION FOR CREDIT CARD PAYMENT -** By signing this application, I authorize Liberty Life Assurance Company of Boston to initiate a one-time charge to the credit card shown on the application for the purpose of meeting premium payment obligations. I agree not to contest this charge upon approval of this credit card transaction.]

INSURING AGREEMENT – I[(We)] declare that all statements and answers given in this application are true and complete to the best of my[(our)] knowledge and belief. I[(We)] also agree that: (1) no agent/insurance producer has the authority to determine insurability, waive any rights or requirements of the Company, or make or modify any contract of insurance; (2) no information obtained by any such person will bind the Company unless set out in writing in a part of the application; (3) all statements and answers given in this application will form the basis for, and become part of, any contract of insurance issued by the Company under this application; and (4) no insurance will take effect on the basis of this application unless: (a) the full first premium has been paid; and (b) the contract has been delivered to and accepted by the applicant without a change in the insurability status of the proposed insured.

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.

X _____
Proposed Insured[/Owner/Guardian] Signature

X _____
[Owner Signature

X _____
Joint Owner Signature (if applicable)

X _____
Payor Signature (if applicable)

X _____
Agent/Insurance Producer Signature (as witness)]

Signed in: _____ on _____
City and State Date