THE CINCINNATI LIFE INSURANCE COMPANY

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
www.cinfin.com ■ 513-870-2000

☐ NEW ☐ INCREASE EXISTING POLICY # _____ FOR INSURED _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE **Please print or type all information**

EMPLOYEE

1. Employee (first, middle, last) | 2. Employment Date | 3. Employee No.

4. Mailing Address No. Street Apt. # City State Zip

5. Phone No. (H) ( ) (W) ( ) | 6. Soc. Sec. No. | 7. Occupation

8. Are you actively at work and currently working at least 20 hours per week? ☐ **Yes** ☐ **No**

9. Date of Birth | 10. St./Ctry. of Birth | 11. Gender ☐ M ☐ F

12. Do you now or have you smoked cigarettes within the last year? ☐ **Yes** ☐ **No**

13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? ☐ **Yes** ☐ **No**

14.

Plan	Amount of Ins.	Premium Incl. Rider(s)
A. ☐ Term	$_____	$_____
B. ☐ Term ROP	$_____	$_____
C. ☐ Universal Life	$_____	$_____
D. ☐ Whole Life	$_____	$_____

15. Mode
☐ Weekly ☐ Bi-Weekly
☐ Semi-Monthly ☐ Monthly
☐ Other _____

16. Optional Benefit Riders: ☐ Accelerated Benefit ☐ CTR - $10,000 ☐ Accidental Death Benefit ☐ FAIR ☐ Waiver of Premium ☐ Other _____

17. Automatic Premium Loan (if available)? ☐ **Yes** ☐ **No**

18. Primary Beneficiary
Name: _____
Relationship: _____
City & State: _____

19. Contingent Beneficiary
Name: _____
Relationship: _____
City & State: _____

OTHER PROPOSED INSURED

20. Other Proposed Insured (first, middle, last) | 21. Other Proposed Insured's Soc. Sec. No.

22. Relationship to Employee: ☐ Spouse ☐ Child ☐ Grandchild | 23. Occupation

24. Mailing Address (if different from above) No. Street Apt. # City State Zip

25. Date of Birth | 26. St./Ctry. of Birth | 27. Gender ☐ M ☐ F

28. Do you now or have you smoked cigarettes within the last year? ☐ **Yes** ☐ **No**

29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? ☐ **Yes** ☐ **No**

30. Owner, if other than Employee: (Name and Address) | 31. Relationship

32. Contingent Owner (Name & Soc. Sec. No.) | 33. Relationship

34.

Plan	Amount of Ins.	Premium Incl. Rider(s)
A. ☐ Term	$_____	$_____
B. ☐ Term ROP	$_____	$_____
C. ☐ Universal Life	$_____	$_____
D. ☐ Whole Life	$_____	$_____

35. Mode
☐ Weekly ☐ Bi-Weekly
☐ Semi-Monthly ☐ Monthly
☐ Other _____

36. Optional Benefit Riders: ☐ Accelerated Benefit ☐ CTR - $10,000 ☐ Accidental Death Benefit ☐ Waiver of Premium ☐ Other _____

37. Automatic Premium Loan (if available)? ☐ **Yes** ☐ **No**

38. Primary Beneficiary
Name: _____
Relationship: _____
City & State: _____

39. Contingent Beneficiary
Name: _____
Relationship: _____
City & State: _____

CTR

40. **CHILDREN'S TERM RIDER** – All unmarried children who are less than age 19 as of date of application. The beneficiary of children's coverage is, in all cases, the owner.

Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee

CGI

(Complete this section only as required by underwriting guidelines.)

41. **CONTINGENT GUARANTEED ISSUE** - In the past 90 days have you been hospitalized due to illness or injury or had medical treatment prescribed by a physician? .....

	Employee		**Other Proposed Insured**	
	Yes	**No**	**Yes**	**No**
	☐	☐	☐	☐

IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46

SI

SIMPLIFIED ISSUE – (Complete this section only as required by underwriting guidelines.)

42. Employee:
Height: _____ ft._____ in.
Weight: _____ lbs.

Primary Physician:
Name: _____
Address: _____
City & State: _____

43. Other Proposed Insured:
Height: _____ ft._____ in.
Weight: _____ lbs.

Primary Physician:
Name: _____
Address: _____
City & State: _____

GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #46

44. In the past five years, have you:

	Employee		**Other Proposed Insured**		**Children (as listed in #40 above)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for cancer, tumor, stroke, high blood pressure or disease of the heart or blood vessels, kidney disease, diabetes, depression or anxiety, been hospitalized or had hospitalization recommended?	☐	☐	☐	☐	☐	☐
b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)?	☐	☐	☐	☐	☐	☐
45. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐	☐	☐	☐	☐

DETAILS

46. **DETAILS OF "YES" ANSWERS:**

Name (Including Children listed in #40)	Date/ Duration	Physician and/or Hospital Name and Address	Question Number, Condition, and Treatment

REPLACEMENT

47. Does the Proposed Insured have any life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company? (Complete any applicable replacement forms) ..... **Yes** ☐ **No** ☐

If "Yes," list and indicate if it is to be replaced, changed or borrowed against as a result of this application.

Proposed Insured	Insurer	Policy Number	Amount	**Replaced? Yes**	**No**
				☐	☐
				☐	☐

AGREEMENT

AGREEMENT: I, the undersigned, agree that: 1. This Application will be part of any policy issued. 2. The answers and statements in this Application are the basis for any policy issued by The Cincinnati Life Insurance Company, and no information about them will be considered to have been given to The Cincinnati Life Insurance Company unless it is stated in this Application. 3. I have read this Application and to the best of my knowledge and belief, all the answers and statements that pertain to me are true and complete. 4. Upon acceptance of a policy other than as applied for, this Application and any amendments shall be for such modified policy. When required by statute or regulation, any change in A. Plan; B. Age; C. Amount; D. Classification; or E. Benefits shall be made only upon written agreement. 5. A sales representative does not have The Cincinnati Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this Application, policy, or receipt, as applicable. **6. The Cincinnati Life Insurance Company shall incur no liability unless: A. This Application is fully completed, dated, signed and witnessed; B. The first premium due is paid in full or the Payroll Deduction Authorization is completed while each proposed insured is alive; C. The insurability of each proposed insured remains as described in this Application and in any supplements to this Application; and D. A policy is formally approved by us and issued on this Application, and delivered to and accepted by the owner.**

I acknowledge having received and read the Important Notice to the Proposed Insured.

☐ I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.

Any person who, with intent to defraud or is knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at: _____ Signed On: _____
City State Month Day Year

_____ _____
Signature of Employee Signature of Other Proposed Insured (if required)

_____
Signature of Owner, if other than Employee

AGENT

For Agent: I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this Application are true and correct. I further certify that to the best of my knowledge and belief, this policy ☐ **Will** ☐ **Will Not** replace or change any existing life insurance or annuity contract now in force.

☐ I certify no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.

_____ _____ _____
Signature of Enrolling Agent Enrolling Agent Name (please print) Enrolling Agent Code #