

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

☐ INCREASE EXISTING POLICY # FOR INSURED □ NEW APPLICATION FOR INDIVIDUAL LIFE INSURANCE Please print or type all information 2. Employment Date 1. Employee (first, middle, last) 3. Employee No. 4. Mailing Address 5. Phone No. (H) (6. Soc. Sec. No. 7. Occupation (W) (10. St./Ctry. of Birth 9. Date of Birth 11. Gender 12. Do you now or have you smoked cigarettes within the last year? Yes **EMPLOYEE** 13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? 14. Plan Amount of Ins. Premium Incl. Rider(s) 15. Mode ☐ Term ☐ Weekly ☐ Bi-Weekly Term ROP B. ☐ Semi-Monthly ☐ Monthly Universal Life ☐ Whole Life ☐ Other 16. Optional Benefit Riders: ☐ CTR - \$10,000 ☐ Accidental Death Benefit ☐ Accelerated Benefit FAIR ☐ Waiver of Premium Other 18. Primary Beneficiary 19. Contingent Beneficiary Name: Name: Relationship: ____ Relationship: City & State: City & State: 20. Other Proposed Insured (first, middle, last) 21. Other Proposed Insured's Soc. Sec. No. ☐ Child 22. Relationship to Employee: Spouse ☐ Grandchild 23. Occupation Apt. # 24. Mailing Address (if different from above) 26. St./Ctry. of Birth 25. Date of Birth 27. Gender INSURED 29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? **PROPOSED** 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) 35. Mode OTHER Term ☐ Bi-Weekly ☐ Weekly Term ROP B. ☐ Semi-Monthly ☐ Monthly Universal Life D. Whole Life Other Accelerated Benefit
Waiver of Premium 36. Optional Benefit Riders: CTR - \$10,000 Accidental Death Benefit 38. Primary Beneficiary 39. Contingent Beneficiary Name: __ Name: Relationship: Relationship: City & State: City & State:

In Continuation of Application for Individual Life Insurance

Please print or type all information

| 40. CHILDREN'S TERM RIDER – All unmarried children who are less than age 19 as of date of application. The | | | | | | | | | | | | | | | |
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| | beneficiary of children's coverage is, in all cases, the owner. | | | | | | | | | | | | | | |
| | Fu | | Date of | | | Relationship | Full Na | mes o | f Prop | osed | Date of | Gender | Rela | tionship | |
| | | Insured Children | Birth | M or I | | to Employee | | ured C | | | Birth | M or F | | nployee | |
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| | | | (Comp | nete tili | 3 300 | dion only as rec | uned by u | iluei wi | illing g | juiueiiiii | 55.) | 0 | ther P | ronosed | |
| l_ | 41. | CONTINGENT GUAR | ANTEED | ISSU | E - In | the past 90 da | vs have vo | u been | 1 | Other Proposed Employee Insured | | | | | |
| CGI | 41. CONTINGENT GUARANTEED ISSUE - In hospitalized due to illness or injury or had me physician? | | | | | | | | | • | | Yes No | | | |
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| | | SIMPLIFIED ISSUE - | (Comple | te this | section | on only as requ | irea by und | erwriti | ng gu | idelines | 5.) | | | | |
| | 42. | Employee: | | | | Primary | Name: _ | | | | | | | | |
| | | Height: ft | | in. | | Primary Physician: | | | | | | | | | |
| | | Height: ft Weight: lb | S. | | | | Address | : | | | | | | | |
| | | | | | | | City & St | ate. | | | | | | | |
| | | | | | | | - Only 0. O. | | | | | | | | |
| | 43. | 43. Other Proposed Insured: | | | | Primary | Name: _ | | | | | | | | |
| | | | | i | | Physician: | | | | | | | | | |
| | | Height: ft Weight: lb |)S. | | | | Address | : | | | | | | | |
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| | In Continuation of Application for Individual | Lite insurance | Plea | ise print or type a | <u>il informatio</u> | <u>on</u> | | | | |
|-------------|--|---------------------------------------|--|--|----------------------|-----------|--|--|--|--|
| ΝΤ | 47. Does the Proposed Insured have any life ins Insurance Company or any other company? | urance or annuities | in force with The Cinc | cinnati Life | | No | | | | |
| ME | | • | a result of this application. Replaced? | | | | | | | |
| REPLACEMENT | - | • | • • | - | | | | | | |
| ĬĔ | Proposed Insured | Insurer | Policy Number | Amount | | No □ | | | | |
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| R | | | | | | | | | | |
| 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 application or files a claim containing a false or de | | | | | | | | | |
| | Signed at: | | Signed On: | | | | | | | |
| | Signed at:City Sta | ite | Signed On: | Month Day | Year | | | | | |
| | | | | · | | | | | | |
| | Signature of Employee | | | ner Proposed Insure required) | ∍d | | | | | |
| | Signature of Owner, if other than Employe | ee | | | | | | | | |
| 11 | 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. | | | | | | | | | |
| AGENT | 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 # | | | | | | | | | |
| | Signature of Enrolling Agent | Enrolling <i>F</i> | dent name (please br | IIIU ⊑IIIOIIING | a Agent Coa | IC # | | | | |