APPLICATION FOR INDIVIDUAL LIFE INSURANCE

☐ {FIDELITY LIFE ASSOCIATION, A LEGAL RESERVE LIFE INSURANCE COMPANY},
{8700 W BRYN MAWR AVE, SUITE 900S, CHICAGO, IL 60631}

☐ {FUTURE COMPANY NAME},
{FUTURE COMPANY ADDRESS}

[☐ New Issue] [☐ Reinstatement of Policy # _____]

PROPOSED INSURED

Full Legal Name of the Proposed Insured **[Gender]** **[Sex [at Birth]]** **[Previous Name]**

Legal Residence Address

[Mailing Address]

[Preferred Phone]
[Number] **[Phone Type]** **[Best Time to Call]**

[Alternate Phone]
[Number] **[Phone Type]** **[Best Time to Call]**

[Phone # for Text Messages] **[Email Address]**

[Other Contact Options]

[Do you authorize the insurer named above (the "Insurer(s)") to use the information provided in this section to contact you for reasons including, but not limited to, autodialed or prerecorded telemarketing or advertising calls or texts? Message and data rates may apply. You are not required to provide this authorization as a condition of purchasing or qualifying for any life insurance from the Insurer(s).
☐ Yes. ☐ No.]

Date of Birth **[Place of Birth (Country/State)]** **[Marital Status]**

SSN **[Driver's License Number]** **[State ID Number]** **[State of Issue]**

COVERAGE

Plan Name **[Plan Type]**

Insurance Amount ($) **[Term Period (years)]**

[Planned Premium ($)] **[Death Benefit Option]**

[Purpose of Insurance]

[Automatic Premium Loan Option ☐ **Yes.** ☐ **No.]**

[Rider Options]

Name of Proposed Insured

OTHER INSURANCE

Do you have any existing life insurance or annuity contracts in force or is any application for life insurance, or reinstatement now pending with any insurance company?
☐ Yes. ☐ No.

If this policy is issued, will any other existing life insurance or annuity contract be cancelled, lapsed or not renewed, or are you considering using funds from your existing policies or contracts to pay premiums on the new policy or contract?
☐ Yes. ☐ No.

[Name of Company] **[Policy ID / Number]** **[Insurance Amount] [($)]** **[Date Issued]** **[To Be Replaced]** [☐ Yes. ☐ No.] **[To Be Financed]** [☐ Yes. ☐ No.]

[Name of Company] **[Policy ID / Number]** **[Insurance Amount] [($)]** **[Date Issued]** **[To Be Replaced]** [☐ Yes. ☐ No.] **[To Be Financed]** [☐ Yes. ☐ No].

OWNER

[Name] **[Type of Owner]** **[Date of Birth]** **[Date of Trust Agreement]** **[SSN]** **[EIN]**

[Address] **[Relationship to Proposed Insured]**

[Preferred Phone] [Number] **[Phone Type]** **[Best Time to Call]**

[Alternate Phone] Number] **[Phone Type]** **[Best Time to Call]**

[Phone # for Texts] **[Email Address]**

[Other Contact Options]

[SECONDARY ADDRESSEE

Do you want to provide a secondary addressee (*This person will receive copies of your overdue premium and lapse notices)*
☐ Yes. ☐ No.

Name **Mailing Address]**

BENEFICIARY

Primary Beneficiary
Type of Beneficiary **Name** **[Date of Birth]** **[Date of Trust Agreement]** **[SSN]** **[EIN]**

[Address] **[Phone Number]** **% of Benefit** **[Relationship to Insured]**

[Contingent Beneficiary]
[Type of Beneficiary] **[Name]** **[Date of Birth]** **[Date of Trust Agreement]** **[SSN]** **[EIN]**

[Address] **[Phone Number]** **[% of Benefit]** **[Relationship to Insured]**

Name of Proposed Insured

QUESTIONS TO THE PROPOSED INSURED

1. [Are you a United States citizen] [or] [do you have Permanent Resident [(Green Card)] Status]?] ☐ Yes. ☐ No.
2. [Are you currently employed?] ☐ Yes. ☐ No.
3. [What is your height (ft/in)?] _____ [What is your weight (lbs)?] _____
4. [Has your weight changed more than {10} pounds within the past {year}?] ☐ Yes. ☐ No.
5. [Are you currently pregnant? (females only)] ☐ Yes. ☐ No.
6. [Are you a member of the armed forces?] ☐ Yes. ☐ No.
7. [{Within the past {5 years} have you} used [tobacco][or][any][other]product that contains nicotine][(Including[, but not limited to]: [cigarettes][, cigars][, e- cigarettes/vaping][, pipe][, chewing tobacco][, snuff][, hookah][, smoking cessation products])]?] ☐ Yes. ☐ No.
8. [{Within the past {5 years} have you} used a vaping device?] ☐ Yes. ☐ No.
9. [{Within the past {2 years} have you} engaged in, or within the next {2 years} do you expect to engage in:
   a. [any aviation activity other than as a passenger on a [commercial] [or] [scheduled] airline?] ☐ Yes. ☐ No.
   b. [any form of [motor racing,] [mountain,] [rock] [or] [ice climbing,] [cave exploration,] [hang gliding,] [scuba] [or] [sky diving]?]] ☐ Yes. ☐ No.
10. [Within the next {2 years}, do you plan to [travel] [or] [reside] outside the United States?] ☐ Yes. ☐ No.
11. [Within the past {2 years}, have you [traveled] [or] [resided] outside the United States?] ☐ Yes. ☐ No.
12. [Have you consulted a physician within the past {5 years}?] ☐ Yes. ☐ No.
13. [Do you have a valid driver's license [or state ID]?] ☐ Yes. ☐ No.
14. [{Within the past {5 years} have you}:
   a. [had your driver's license [suspended] [or] [revoked]?] ☐ Yes. ☐ No.
   b. [pled guilty to] [or] [been convicted of] [reckless driving] [or] [driving under the influence of alcohol or drugs]?]] ☐ Yes. ☐ No.
15. [{Within the past {5 years} have you} [pled guilty to] [or] [been convicted of] any moving violations?] ☐ Yes. ☐ No.
16. [{Within the past {5 years} have you} been the subject of any bankruptcy proceedings?] ☐ Yes. ☐ No.
17. [{Within the past {5 years} have you}:
   a. [used [marijuana,] [cocaine,] [heroin,] [narcotics,] [hallucinogens] [or] [other controlled substances (not prescribed by a physician)]?] ☐ Yes. ☐ No.
   b. [been counseled, treated, or advised by a physician to discontinue or seek treatment for use of [illegal drugs,] [alcohol] [or] [prescription drugs]?] ☐ Yes. ☐ No.
   c. [been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?] ☐ Yes. ☐ No.
   d. [[pled guilty to] [or] [been convicted of] any felony?]] ☐ Yes. ☐ No.
18. [[How often] do you use tobacco or nicotine products?] _____
19. [[How often] do you using a vaping device?] _____
20. [How many alcoholic beverages do you consume on a [weekly] basis?] _____
21. [[How often] do you consume drugs other than those prescribed by a licensed medical professional?] _____
22. [[How often] do you consume drugs in a manner other than as prescribed by a licensed medical professional?] _____
23. [{Within the past {5 years} have you} [received] [or] [applied for] any kind of [disability benefits,] [workman's compensation,] [worker's compensation,] [Social Security Disability benefits,] [nursing home benefits,] [home health care benefits,] [assisted living facility benefits,] [adult day care benefits] [or] [long term care benefits]?] ☐ Yes. ☐ No.
24. [{Within the past {5 years} have you} had an application for health or life insurance, [rated up,] [postponed] [or] [declined]?] ☐ Yes. ☐ No.
25. [[Have you {ever} [been convicted in], [or] [pled guilty to] a criminal proceeding][,] [been on probation][,] [been on parole] [or] [do you have criminal charges pending]?] ☐ Yes. ☐ No.
26. [{Within the past {10 years} have you} [been diagnosed,] [been treated,] [been tested,] [consulted with,] [or] [been given medical advice] [by] a member of the medical profession for:
   a. [[cancer (other than basal cell skin cancer)], [cancer,] [tumor,] [polyp,] [leukemia,] [lymphoma] [or] [melanoma] [or any other malignancy]?] ☐ Yes. ☐ No.
   b. [[anemia] [or] [any other disorder of the blood]?] ☐ Yes. ☐ No.
   c. [[heart attack,] [stroke,] [chest pain,] [coronary artery disorder,] [heart murmur,] [transient ischemic attack (TIA),] [irregular heartbeat,] [elevated blood pressure,] [myocarditis,] [elevated cholesterol] [or] [any other disorder of the [heart,] [blood vessels] [or] [peripheral vascular system]]?] ☐ Yes. ☐ No.

QUESTIONS TO THE PROPOSED INSURED (continued)

d. [[ulcerative colitis,] [hepatitis,] [disorder of the [esophagus,] [intestines,] [liver disorder] [or any other digestive disorder]]?] ☐ Yes. ☐ No.

e. [[diabetes,] [Type 1 diabetes,] [Type 2 diabetes,] [diabetic complications,] [elevated blood sugar,] [thyroid,] [adrenal,] [pituitary] [or] [pancreas disorder] [or] [any other gland or endocrine disorder]?] ☐ Yes. ☐ No.

f. [[kidney disorder,] [bladder disorder,] [prostate disorder,] [disorder of the breast] [or] [any other disorder of the [urinary tract] [or] [the reproductive system,] [or] [any sexually transmitted disease]]?] ☐ Yes. ☐ No.

g. [[asthma,] [shortness of breath,] [chronic bronchitis,] [chronic obstructive pulmonary disease (COPD),] [cystic fibrosis,] [emphysema,] [Acute Respiratory Distress Syndrome (ARDS),] [sleep apnea] [or] [any other respiratory disorder (other than asthma),][or] [any other respiratory disorder] [or] [required the use of a ventilator]?] ☐ Yes. ☐ No.

h. [[any [muscle,] [neck,] [back,] [spine,] [bone] [or] [joint] [disorder], [or] [disorder of the skin]?] ☐ Yes. ☐ No.

i. [[Alzheimer's disease], [dementia,] [Down's Syndrome,] [Parkinson's disease,] [organic brain syndrome,] [cognitive impairment (of any degree),] [or][amyotrophic lateral sclerosis (ALS),] [anxiety,] [depression,] [ADD/ADHD,] [bipolar disorder,] [Bipolar 1,] [Bipolar 2,] [schizophrenia,] [autism,] [seizures,] [paralysis,] [multiple sclerosis,] [dizziness] [or] [any other mental, nervous or psychiatric disorder,] [or] [attempted suicide]?] ☐ Yes. ☐ No.

j. [[lupus,] [scleroderma,] [rheumatoid arthritis] [or] [any other connective tissue or immune system disorder (other than related to HIV/AIDS)]?] ☐ Yes. ☐ No.

k. [[any organ transplant] [or] [diabetic complications (amputation, coma, or blindness)]?] ☐ Yes. ☐ No.

27. [{Have you ever been diagnosed by a member of the medical profession as having} [acquired immune deficiency syndrome (AIDS)] [or] [AIDS related complex (ARC),] [or tested positive for human immunodeficiency virus (HIV)]?] ☐ Yes. ☐ No.

28. [{Within the past {5 years}, have you} been advised by a member of the medical profession, to have any [hospitalization,] [surgery] [or] [medical test (other than related to HIV/AIDS)] that has not yet been completed?] ☐ Yes. ☐ No.

29. [{Within the past {5 years} have you} been diagnosed with, consulted a member of the medical profession or been treated or been prescribed a medication for any other disease, disorder or condition, or had surgery, hospitalization or medical test (other than related to HIV/AIDS) not mentioned in this application?] ☐ Yes. ☐ No.

30. [{Within the past {5 years} have you} been advised by a member of the medical profession to have any medical appointment that has not yet been completed?] ☐ Yes. ☐ No.

31. [{Within the past {5 years}, in addition to the information already given have you had any} [medical tests (other than related to HIV/AIDS)] [or] [procedures,] [stress tests,] [echocardiograms,] [x-rays,] [CAT scan] [or] [MRI]?] ☐ Yes. ☐ No.

32. [{Within the past {5 years}, have you had any} [medical tests (other than related to HIV/AIDS)] [or] [procedures,] [stress tests,] [echocardiograms,] [x-rays,] [CT scan] [or] [MRI] performed for which results have not yet been received?] ☐ Yes. ☐ No.

33. [[{Have either of your natural parents,][or] [has any sibling] been diagnosed by a medical professional with, or died from}, [COVID-19,] [cancer,] [diabetes,][heart] [or] [kidney] [disease] before the age of {65}?] ☐ Yes. ☐ No.

34. [Do you currently have a mortgage?] ☐ Yes. ☐ No.

35. [{Are you currently} [on oxygen for a medical condition,] [an] [inpatient] [or] [outpatient] [in a] [hospital,] [clinic] [or] [medical facility,] [or any similar entity,] [or] [confined to a nursing facility] [or] [assisted living facility]?] ☐ Yes. ☐ No.

36. [{Within the past {six months},} [have you been hospitalized two or more times,] [or] [have you been advised by a member of the medical profession [to have any hospitalization] [or] [to be admitted to a nursing facility] that has not yet been completed]?] ☐ Yes. ☐ No.

37. [Have you been diagnosed by a member of the medical profession as having a life expectancy of {24 months} or less?] ☐ Yes. ☐ No.

38. [{Within the past {5 years} have you} [been diagnosed,] [been treated,] [been tested,] [consulted with,] [or] [been given medical advice] [by] a member of the medical profession, for [COVID-19,] [MERS,] [SARS,] [or any other viral disorder other than [a cold] [or] [flu]]?] ☐ Yes. ☐ No.

39. [{Within the past {5 years} have you} been advised by a member of the medical profession to [quarantine] or [self-isolate][due to [fever,][cough,][shortness of breath,] [sore throat,] [runny nose,] [fatigue,][or any other reason]]?] ☐ Yes. ☐ No.

40. [{Within the past {2 years} have you} been hospitalized for a mental disorder?] ☐ Yes. ☐ No.

41. [{Within the past {2 years} have you} been hospitalized for a psychiatric disorder?] ☐ Yes. ☐ No.

42. [{Within the past {5 years}, have you} been [an] [inpatient] [or] [outpatient] [in a] [hospital,] [clinic] [or] [medical facility,] [or] [any similar entity]?] ☐ Yes. ☐ No.

QUESTIONS TO THE PROPOSED INSURED (continued)

43. [[Do you [require] [assistance] [or] [supervision] [or] use any type of medical equipment to perform any [of the following] Activities of Daily Living:
    a) [Eating?] ☐ Yes. ☐ No.
    b) [Bathing?] ☐ Yes. ☐ No.
    c) [Dressing?] ☐ Yes. ☐ No.
    d) [Getting into or out of bed][or] [[functional]transferring]? ☐ Yes. ☐ No.
    e) [Maintaining bladder and bowel functions?] ☐ Yes. ☐ No.
    f) [Getting on or off the toilet?]] ☐ Yes. ☐ No.
44. [Is any Proposed Child (Children) to be insured now taking medication, [by prescription] [or] [over the counter (OTC)]?] ☐ Yes. ☐ No.
45. [Is any Proposed Child (Children) to be insured undergoing [treatment] [or] [therapy] of any kind by a member of the medical profession?] ☐ Yes. ☐ No.
46. [Has any Proposed Child (Children) to be insured [ever] been diagnosed with or treated by a physician for any physical disability?] ☐ Yes. ☐ No.
47. [Has any Proposed Child (Children) to be insured [ever] been diagnosed with or treated by a physician for any mental disability?] ☐ Yes. ☐ No.
48. [Has any Proposed Child (Children) to be insured [ever] been diagnosed with or treated by a physician for any disorder of the heart?] ☐ Yes. ☐ No.
49. [Has any Proposed Child (Children) to be insured [ever] been diagnosed with or treated by a physician for any disorder of the lung?] ☐ Yes. ☐ No.
50. [Has any Proposed Child (Children) to be insured [ever] been diagnosed with or treated by a physician for cancer?] ☐ Yes. ☐ No.
51. [Within the last [5 years], has any Proposed Child (Children) to be insured been advised by a member of the medical profession to have any surgery which has not yet been completed?] ☐ Yes. ☐ No.
52. [Within the last [5 years], has any Proposed Child (Children) to be insured been advised by a member of the medical profession to have any hospitalization which has not yet been completed?] ☐ Yes. ☐ No.

Name of Proposed Insured

[PAYMENT PLAN

As a convenience to me, I authorize {Agency Name and} the insurer named on page one (the "Insurer(s)") to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below or otherwise provided. I understand that if a debit or withdrawal is not honored by the financial institution, {Agency Name and} the Insurer(s) will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be re-deposited by {Agency Name or} the Insurer(s) at their sole discretion. This authorization will remain in effect until written notice by the depositor/card holder is received by {Agency Name or} the Insurer(s). I further agree that if any such debit or withdrawal is not honored, whether with or without cause, {Agency Name and} the Insurer(s) shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.

[Payor Name] **[Type of Payor]** **[Payor Address]**

Initial Payment
Payment Mode **Payment Method** **[Draw Date (Day of the Month)]**

[Card Type] **[Name of Bank]**

[Other Payment Details]

Amount Paid with Application ($)

[Recurring Payment]
[☐ Same as Initial]
[Payment Mode] **[Payment Method]** **[Draw Date (Day of the Month)]**

[Card Type] **[Name of Bank]**

[Other Payment Details]

[Secondary Payment Option]
[Do you want to provide a secondary payment option (*This option will be used in case of failure of the payment method(s) noted above.)*
☐ Yes. ☐ No.]

[☐ Initial Payment.] [☐ Recurring Payment.] [☐ Both.]

[Payment Mode] **[Payment Method]** **[Draw Date (Day of the Month)]**

[Card Type] **[Name of Bank]**

[Other Payment Details]

[Printed Name (As it appears on file with the financial institution)]
_____

Signature of Payor **[Reference #]**
_____ _____]

Name of Proposed Insured

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I declare that each answer and statement given to the questions contained in this application is complete, true and correctly recorded to the best of my knowledge and belief. I understand and agree that this application and my answers and statements in it will be shared with {Agency Name and} the insurer(s) named on page one (the "Insurer(s)") for the purpose of determining insurability and ultimately obtaining securing offers of insurance coverage from the Insurer(s) on the life of the Proposed Insured. The Insurer(s) named in this application will rely on these answers, and the answers and statements I may give in any other form, taken as a part of this application, as representations and not warranties. No answer or statement shall void the policy, if issued, unless the answer or statement is contained in a written application which has been endorsed and attached to the policy. I also understand that the Insurer(s) reserve(s) the right to accept or deny this application after taking into account whatever information may be available to it, including availability of coverage by its reinsurers.

I understand that the statements and answers in this application are the basis for the policy, if issued, and that no information will be considered to have been given to the Insurer(s) unless it is stated in the application. I understand that {Agency Name and} their representatives do not have authorization of the Insurer(s) to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy, or receipt, as applicable.

I understand that no Insurer(s) will have any liability until a policy is issued on this application, that policy is delivered to and accepted by the Owner and the first premium is paid in full while the Proposed Insured is alive.

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency or employer to provide to the Insurer(s), or their reinsurers or other designee, for underwriting purposes, any information they might have about me regarding the diagnosis, treatment, prescription, and prognosis of any physical or mental condition, my driving record, avocations, credit history, insurance history, occupation, character, and hobbies, as applicable. To facilitate the rapid transmission of such information, I authorize all said sources, except MIB, Inc., to give such records to any agency employed by the Insurer(s).

I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed or a time limit that complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my application for insurance. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization. I also understand that I have the right to revoke this authorization at any time. A written statement revoking this Authorization delivered to {Agency Name or} the Insurer(s) at its usual business address will revoke this Authorization.

All or part of the information obtained with this Authorization may be disclosed to a physician of my choosing, my insurance agent, MIB, Inc., and to other persons or organizations performing business or legal services in connection with this application, including reinsuring companies, and as may be required by law.

I authorize the Insurer(s) or reinsurers to make a brief report of my protected health information to MIB, Inc.

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.

I hereby acknowledge that this application constitutes an invitation to the Insurer(s) to make an offer of life insurance coverage. I further acknowledge that the Insurer(s) is (are) in no way obligated to extend such an offer. I understand that, if an offer is made, no coverage is in place until I receive and accept the policy and pay the required initial premium.

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

Name of Proposed Insured

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION (continued)

Signed this Date City State

[Printed Name of Proposed Insured]

Signature of Proposed Insured [Reference #]

[Printed Name of Owner if other than Proposed Insured]

[Signature of Owner if other than Proposed Insured] [Reference #]

PRODUCER STATEMENT

[To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any proposed insured?
☐ Yes. ☐ No.]

[Does any Proposed Insured have existing life insurance or annuity contracts in force?
☐ Yes. ☐ No.]

Writing Agent Name Writing Agent ID [State License Identification Number]

[Email Address of Writing Agent] [Telephone Number of Writing Agent]

[General Agent Name] [General Agent ID]

[Assistant Licensed Agent Name] [Assistant Licensed Agent ID]

Writing Agent Signature [Reference #]