MOTORISTS LIFE INSURANCE COMPANY
471 East Broad Street, Columbus, Ohio 43215

EASY APP

Individual Life Insurance Application on Base Insured

(Please Print & Use Black Ink)

Agent # _____
Application Date _____

1. PERSONAL INFORMATION ABOUT 1st INSURED **Driver License #** _____

Name of Proposed Insured (First, Middle, Last) (Former)	**Sex** ☐M ☐F	**Marital Status** ☐M ☐S	**Date of Birth** / /
Home Address **City** **State** **Zip**	**Birthplace** (State or Country)	**Social Security #**	
Home Phone **Alternative Phone**	**County** **(Within City Limits)** ☐**Yes** ☐**No**		
Email Address			

2. COVERAGE APPLIED FOR **FACE AMOUNT $** _____

☐ **Non-Par WL** ☐ **Level Term** _____ **yrs**

☐ **Universal Life**

☐ **(A) Level Death Benefit**
☐ **Lifetime Guarantee Rider**

☐ **(B) Increasing Death Benefit**

☐ **Participating Whole Life**

Participating Whole Life Plans Dividend Options*
☐ **Paid up additions (PUA)** ☐ **PREM PAY** ☐ **ACCUM** ☐ **Cash** ☐ **1 yr. Term**
*If no option selected, PUA is automatic option

3. RIDERS AND BENEFIT OPTIONS

☐ Accidental Death Benefit (ADB) $_____
☐ Option to Purchase (OPR) _____ Units
☐ Disability Income
$_____ amount applied for
☐ Joint ☐ Individual
☐ 2 Year Benefit Period ☐ 5 Year Benefit Period

Primary Insured
☐ Level Term Rider $ _____
☐ Decreasing Term Rider $ _____
15 year _____ 30 year _____

☐ Waiver of Premium ☐ Waiver of Monthly Deduction (UL)
☐ Accelerated Benefit Rider
☐ Other Insured Rider (complete #9-12 on pg **2**)
☐ Children's Term Rider (complete #11 on pg. **2**)
☐ Other _____

Participating Whole Life Additional Riders
Paid up Additions Rider (PUAR)
☐ Single ☐ Annual ☐ $_____ (Prem.)

☐ YES ☐ NO Automatic Premium Loan Provision

4. PREMIUM MODE

☐ Annual ☐ Semi ☐ Quarterly ☐ EFT ☐ Payroll Deduction ☐ Single ☐ Other _____ ☐ Check if 1035 Exchange
1st Payment $_____ Mode Premium $_____ (if EFT, submit authorization form)

4a. PAYOR INFORMATION (If Payor is other than owner or insured)

Name of Payor _____ Address _____
Relation to Proposed Insured _____ Payor's Social Security # _____

5. OWNER INFORMATION (If different from 1st insured)

Name of Owner:	Address:
Relation to Proposed Insured:	Owner's Social Security or Tax ID#:

6. 1st INSURED BENEFICIARY INFORMATION (Give Full names, relationships and Social Security #'s)

Primary:	Relationship	Social Security #
Address:		
Contingent:	Relationship	Social Security #
Address:		

Complete question 7 pg 2

7. INSURED(S) INSURANCE HISTORY - Complete Replacement Forms if Necessary

1st Ins. 2nd Ins.

a. Have the person(s) proposed for insurance applied for life insurance with any other company in the past 120 days? ☐ Y ☐ N ☐ Y ☐ N
If yes to any questions below, give details in the remarks section of #12, including the company name and outcome.

b. Do you have any life insurance or annuity in force? ☐ Y ☐ N Total Life in Force $ _____ $ _____

c. Will this policy replace or change any existing Life Insurance or annuity policy in this or any other company? ☐ Y ☐ N ☐ Y ☐ N
If yes, is it Group life insurance? ☐ Y ☐ N See specific state replacement form.

(If answer to B or C is yes, check state requirements for replacement form submission)

d. Have you entered into, discussed or are you considering entering into any form of settlement with respect to this policy being applied for? ☐ Y ☐ N ☐ Y ☐ N

e. Will the premium for this policy being applied for be funded by any premium financing agreement not secured by personal assets? ☐ Y ☐ N ☐ Y ☐ N

f. Is there an agreement between the applicant and another person or business entity to sell the policy for a price or otherwise transfer the ownership or beneficial interest in the policy through assumption or forgiveness of a loan for the premium? ☐ Y ☐ N ☐ Y ☐ N

8. OTHER INSURED RIDER

☐ Level Term Rider $ _____ ☐ Decreasing Term Rider $ _____
_____ yrs. 15 year _____ 30 year _____

9. PERSONAL INFORMATION ABOUT OTHER INSURED

Drivers License # _____

Name of Proposed Insured (First, Middle, Last) (Former)	**Sex** ☐M ☐F	**Marital Status** ☐M ☐S	**Date of Birth** / /
Home Address **City** **State** **Zip**	**Birthplace** (State or Country)	**Social Security #**	
Home Phone **Alternate Phone**	**County** **(Within City Limits)** ☐ **Yes** ☐ **No**		

10. OTHER INSURED BENEFICIARY INFORMATION (Give Full names, relationships and Social Security #'s)

Primary:	Relationship to other Insured	Social Security #
Contingent:	Relationship to other Insured	Social Security #

11. CHILDREN'S TERM RIDER $ _____ Units

Child's Name	**HT**	**WT**	**DOB**	**Child's Name**	**HT**	**WT**	**DOB**
1.				3.			
2.				4.			

12. REMARKS

AGREEMENTS

All physicians, medical practitioners, hospitals, clinics, sanitariums or other medically-related facilities, insurance companies, MIB Inc., Employer or other organizations, institutions, or persons are authorized to give Motorists Life Insurance Company and the company's underwriters or its reinsurers all "Medical and/or Non-Medical" information and any other record of knowledge, including dates, treatments, observations and prognosis for me, my health, my family, and the health of my family for the purpose of underwriting this application for insurance. Motorists Life Insurance company and the Company's underwriters or its reinsurers may make a brief report of my personal health information to MIB Inc. A copy of this authorization will be valid as the original. This authorization is valid within the time period permitted by applicable law in the state where the policy is delivered or issued for delivery. You or your authorized representative is entitled to receive a copy of this completed authorization form.

Applicant's Statement:

I have read the completed application. The above representations are true to the best of my knowledge and belief. I understand all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I agree the policy shall not be in effect until it has been issued by the Company during my lifetime. 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 Incontestability Provision. I understand that the agent has no authority to approve an 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 have read and acknowledge the answers to a. and b. in the Agent's Statement.

A compliant illustration ☐was ☐was not provided to me at the time of sale. I understand if required a compliant illustration will be provided to me at the time of policy delivery.

ANY INSURANCE APPROVED BY THE COMPANY FOR ISSUANCE AS A RESULT OF THIS APPLICATION SHALL BE CONSIDERED IN FORCE ONLY WHEN A POLICY IS ISSUED BY THE COMPANY AND SAID POLICY MANUALLY RECEIVED AND ACCEPTED BY THE APPLICANT, THE FIRST PREMIUM HAS BEEN PAID AND THE INFORMATION PROVIDED IN THE APPLICATION HAS NOT CHANGED.

I have paid the sum of $ _____ with this Application, dated at _____
City State

this _____ day of _____ / _____ .
Month Year

X _____
Signature of Proposed Insured: parent or guardian if under 18 in the State of Pennsylvania. Under 15 in all other states.

X _____
Signature of 2nd Insured: parent or guardian if under 18 in the State of Pennsylvania. Under 15 in all other states.

X _____
Signature of Owner (if not Proposed Insured)

AGENT'S STATEMENT

a. To the best of my knowledge, the insurance applied for ☐ **will** ☐ **will not** replace any existing life insurance or annuity.

b. To the best of my knowledge, there is _____ is not _____ any existing life insurance or annuity in force (if yes, check state requirements for replacement form submission)

c. If required by State Regulation: A compliant illustration ☐ **was** ☐ **was not** used in this sale. (If yes, illustration must be submitted with the application). If a compliant illustration is not used one will be provided no later than the time of policy delivery.

I further certify that any information recorded by me on this application is true and accurate to the best of my knowledge.

X _____ / _____ / _____ / _____ / _____
Agent's Signature | Agent Print Name | Agency # | Producer # | Split %

X _____ / _____ / _____ / _____ / _____
Agent's Signature | Agent Print Name | Agency # | Producer # | Split %

_____
Agent's Business Phone Number

MOTORISTS LIFE INSURANCE COMPANY
471 E. Broad St., Columbus, OH 43215-3861

CONDITIONAL RECEIPT - Give this receipt to the insured

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS ALL CONDITIONS OF THIS RECEIPT ARE MET. *No agent has the authority to alter or waive the terms or conditions of this receipt.*

If (1) an amount equal to the first full premium is submitted;

(2) and all underwriting requirements required by the Company are completed within 90 days from the application date;

(3) and the person(s) proposed for the insurance are, on the application date, a risk acceptable for insurance exactly as applied for at a standard rate without modification of premium rate, or amount applied for;

then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date of completion of all underwriting requirements, or (c) any date of issue requested in the application.

The total amount of insurance (Life Insurance and Accidental Death Benefits), which may become effective prior to the policy delivery shall not exceed $500,000 per person. If the person(s) are not acceptable risk(s), we will refund the amount paid.

NOTIFICATION OF INVESTIGATIVE REPORT

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you, your family, friends, neighbors, and associates. Upon written request to the Manager, New Business Department, at the above address, further information on the nature and scope of the report will be provided.

MIB Inc., DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Motorists Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB Inc., a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (www.mib.com). If you question the accuracy of 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.

Motorists Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

ATTENDING PHYSICIAN REPORT DISCLOSURE NOTICE

As part of our underwriting process, a report may be obtained from your personal physician, hospital or other medical facility. This report may provide information on your medical history including diagnoses, medications, hospitalizations or treatment. This information may have a direct influence on the underwriting decision that we make.

Due to the confidential nature of the information contained in these reports, we are not able to disclose this information directly to you. If you would like details of this information or if you question the accuracy of this information we use in our underwriting process, we would be happy to provide that information to a physician of your choice. Upon receipt of a written request, including the complete name and address of the physician, to the Manager, Life Underwriting, at the above address, further information on the nature and scope of the information from the report will be provided to the named physician.

NOTIFICATION OF ANTI-FRAUD LAW TO APPLICANTS APPLYING FOR LIFE INSURANCE

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 law.