VANTIS LIFE INSURANCE COMPANY

[200 DAY HILL RD, WINDSOR, CT 06095
1-866-826-8471 WWW.VANTISLIFE.COM]

PART 1A: Application for Individual Life Insurance

♦ PLAN OF INSURANCE

Plan of Insurance: Level Term Life Insurance—Non Participating

Amount and Type of Coverage Requested:

[❑10 Year Level ❑20 Year Level ❑30 Year Level
❑15 Year Level ❑25 Year Level $_____]

[❑ **Intermediate Endowment Rider*** (Available on 20, 25, 30-Yr Level Term Only)
❑ **Disability Waiver of Premium Rider*** (Available for ages 21-55)]

*additional costs apply.

♦ PREMIUM PAYMENT SCHEDULE

❑ Annually ❑ Semi-Annually ❑ Quarterly
❑ Monthly (*electronic payment method only)*

❑ Check here if you wish to pay electronically via Electronic Fund Transfer or Credit Card. Please submit Premium Payment Charge Authorization Form.

Premium Paid $_____
(Payment with Application)

♦ PROPOSED INSURED INFORMATION

First Name: Middle Initial: Last Name: Gender: ❑Male ❑Female

Date of Birth (mm/dd/yyyy) Place of Birth (State/Country): Social Security #:

Does the Proposed Insured have a valid Drivers License? ❑ Yes ❑ No or ❑ No, have never been issued a license.
If Yes, Provide Drivers License #:_____ State:_____
If No, Please provide details in the **Additional Information Section**

Is the Proposed Insured a U.S. Citizen? ❑ Yes ❑ No Is the Proposed Insured a U.S. Permanent Resident? ❑ Yes ❑ No
Does the Proposed Insured hold an active & current Green Card? ❑ Yes ❑ No, If yes, please provide Green Card #:

Home Address (Number, Street, and Apt.#) *(No P.O. Box please)* Phone (HOME/CELL): (WORK):

City State Zip Email Address

Mailing Address if different than home (Number, Street, Apt#) City State Zip

Is the Proposed Insured currently employed? ❑ Yes ❑ No Occupation _____
Annual Income (If retired or unemployed provide Household Income):

Employer's Name & Address:

Is the Proposed Insured currently disabled ❑ Yes ❑ No If Yes, please provide details in the **Additional Information Section**
If No, please provide reason for unemployment in **Additional Information Section**
Has the Proposed Insured collected disability benefits in the last two years? ❑ Yes ❑ No

♦ [CHARITABLE GIVING RIDER—CHARITY ELECTION:]

[The Charitable Giving Rider provides for a donation payable to an IRS section 501(c)(3) qualified charity on your behalf by Vantis Life. **There is no additional cost for this rider. The donation will not change your premium or reduce the amount your beneficiary receives**.
I have a preferred Charity: Charity Name:_____
Address: _____
The Internal Revenue Service provides the following website https://apps.irs.gov/app/eos/ where you may search by **Organization Name** to find your charity of choice. If you are unable to name a charity at this time, you may call Vantis Life or visit our website above to obtain a Charity Election Form.]

For Agency Use Only		
Agency:	Producer #:	
Date Prem Rec'd	Branch #	Rec'd By

For Home Office Use Only			
Pol. No.		Issue Date	Ins. Amount
❑ APP ❑ DEC ❑ W/D ❑ PP	UND.____ Date __/__/__	Age (ANB)	Amt. Of Premium

♦ OWNER INFORMATION: (If other than Proposed Insured)

Owner's First Name:	Middle Initial:	Last Name:	Owner's Social Security #:
Owner's Relationship to Proposed Insured:			
Owner's Address (Number, Street, and Apt.#):			
City:	State:	Zip:	
Phone (HOME/CELL):	(WORK):		
Email:			
Annual Income: $			

♦ BILLING ADDRESS

Payor's Name, if other than Owner :
Address (Number, Street, and Apt.#):
City:
State:
Zip:

♦ INSURANCE REPLACEMENT QUESTIONS

1. Does the Proposed Insured have existing life insurance or annuity contracts in force? ❑ Yes ❑ No
   If Yes, provide total amount of coverage: _____
2. Does the Proposed Insured have any applications for life insurance now pending? ❑ Yes ❑ No
   If Yes, provide total amount of coverage: _____
3. Do you intend to replace, discontinue or change any existing life insurance or annuity contracts on the Proposed Insured with the applied-for policy? ❑ Yes ❑ No
   If yes, complete state required forms and provide Company Name(s): _____
   Total Amount of Coverage: _____

PART 1B - INSURANCE INFORMATION ON THE PROPOSED INSURED

Current Height: _____Ft. _____ Ins. Current Weight:_____ Lbs.

1. Has the Proposed Insured's weight changed by more than 10 pounds in the last year? ❑ Yes ❑No
2. Is the Proposed Insured currently confined to a hospital, nursing home, psychiatric facility or currently receiving home health care/assisted living care? ❑ Yes ❑No
3. Has the Proposed Insured ever been declined, postponed, or offered rated life or health insurance or been denied a reinstatement, reissue or renewal for life or health insurance? ❑ Yes ❑No
4. In the past three years has the Proposed Insured or does the Proposed Insured intend in the next two years to:
   a. pilot an aircraft (other than scheduled commercial or corporate aviation? ❑ Yes ❑No
   b. engage in any of the following: sky sports, underwater sports to a depth of greater than 100 feet, climbing sports greater than 5.0 difficulty, motor sport traveling at speeds (in any type vehicle) in excess of 100 miles per hour or bungee jumping, heli-skiing, hang gliding, sky diving, parachuting, base jumping? If Yes, complete Questionnaire ❑ Yes ❑No
5. Has the Proposed Insured used tobacco products or products containing nicotine in any form (to include cigarettes, electronic cigarettes, cannabis cigarettes, snuff/chew/dip, cigars, pipes, nicotine patch and nicotine gum) in the past 5 years ❑ Yes ❑No
6. In the next 12 months, does the Proposed Insured intend to live or travel outside the U.S or Canada? ❑ Yes ❑No
7. In the last ten years, has the Proposed Insured:
   a. been convicted of a felony; convicted of a misdemeanor; or is the Proposed Insured currently on parole or incarcerated in a correctional institution? ❑ Yes ❑No
   b. been convicted of operating a vehicle while under the influence of alcohol or drugs; or does the Proposed Insured currently have a revoked or suspended license? ❑ Yes ❑No
8. In the last three years, has the Proposed Insured plead guilty to or been convicted of three or more moving violations? ❑ Yes ❑No

Please provide details to all questions answered "Yes" in the ADDITIONAL INFORMATION SECTION provided.

PART 2B - INSURANCE INFORMATION ON THE PROPOSED INSURED

1. In the past ten years, has the Proposed Insured been diagnosed with or treated by a licensed member of the medical profession for any of the following?:
   a. Disease of heart, blood vessels, high blood pressure, heart murmur, coronary artery disease, chest pain, palpitation or other abnormal heart rate or rhythm, or heart attack? ❑ Yes ❑ No
   b. Disease or disorder of lungs, nose, sinus or throat, including asthma, tuberculosis, emphysema, chronic bronchitis, cough, shortness of breath, or sleep disorder/apnea? ❑ Yes ❑ No
   c. Disease or disorder of the pancreas, esophagus, stomach or intestinal tract including abdominal pain or internal bleeding, ulcer or jaundice? ❑ Yes ❑ No
   d. Disease of kidney, urinary bladder, liver or gall bladder, prostate, or protein, blood or sugar in urine? ❑ Yes ❑ No
   e. Disease or disorder of the brain or nervous system including headache, dizziness, epilepsy or seizures, paralysis, stroke, depression, anxiety or mental illness? ❑ Yes ❑ No
   f. Diabetes, thyroid condition or other glandular disorder or gout? ❑ Yes ❑ No
   g. Disorder of the skin, lymph glands, muscles, bones, joints, arthritis or back disorder? ❑ Yes ❑ No
   h. Disorder of the eye or ear, or any impaired sight or hearing? ❑ Yes ❑ No
   i. Tumor, cancer, anemia, or blood disorder? ❑ Yes ❑ No
   j. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? ❑ Yes ❑ No
2. Has the Proposed Insured ever:
   a. Been treated or counseled for alcoholism, alcohol abuse or addiction? ❑ Yes ❑ No
   b. Used amphetamines, heroin, narcotics, barbiturates, cocaine, hallucinogens, cannabis or any drugs except prescribed by a physician? ❑ Yes ❑ No
   c. had a positive result on a Human Immunodeficiency Virus (HIV) test administered by a member of the medical profession? ❑ Yes ❑ No
3. Other than the above, is the Proposed Insured now under observation or receiving treatment or counseling by a member of the medical profession? ❑ Yes ❑ No
4. Does the Proposed Insured have a regular personal physician? ❑ Yes ❑ No
5. Has a biological parent or sibling of the Proposed Insured died or been diagnosed or treated by a licensed member of the medical profession with heart disease, stroke, or cancer prior to the age of 60? ❑ Yes ❑ No

Please provide details to all questions answered "Yes" in the ADDITIONAL INFORMATION SECTION provided.

♦ ADDITIONAL INFORMATION SECTION (ATTACH SEPARATE SHEET IF MORE SPACE NEEDED)

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♦ BENEFICIARY INFORMATION (ATTACH SEPARATE SHEET IF MORE SPACE NEEDED)

❑ Primary or ❑ Contingent	Name:	Relationship to Insured:		Split%*
Beneficiary Social	Security Number	Date of Birth:	Home Telephone:	
Address (Number, Street)		City	State	Zip
❑ Primary or ❑ Contingent	Name:	Relationship to Insured:		Split%*
Beneficiary Social	Security Number	Date of Birth:	Home Telephone:	
Address (Number, Street)		City	State	Zip
❑ Primary or ❑ Contingent	Name:	Relationship to Insured:		Split%*
Beneficiary Social	Security Number	Date of Birth:	Home Telephone:	
Address (Number, Street)		City	State	Zip
❑ Primary or ❑ Contingent	Name:	Relationship to Insured:		Split%*
Beneficiary Social	Security Number	Date of Birth:	Home Telephone:	
Address (Number, Street)		City	State	Zip
❑ Primary or ❑ Contingent	Name:	Relationship to Insured:		Split%*
Beneficiary Social	Security Number	Date of Birth:	Home Telephone:	
Address (Number, Street)		City	State	Zip

****Split percentages within designated beneficiary classification must equal 100%. If none specified, benefit will be split equally by class.***

♦ DISCLOSURE

I represent to the best of my knowledge and belief that the answers and statements in this application consisting of all Parts, and any amendments, are true, complete and correctly recorded. I acknowledge that Vantis Life Insurance Company will rely on these answers and statements in determining whether, and on what terms, to issue a policy and that no information about the Proposed Insured will be considered to have been given to the Company for the purposes of issuing the policy unless it is stated in the application, and that the Proposed Insured will notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of the policy. I understand that if any answers and/or statements are false, incomplete or incorrectly recorded, any policy issued may be void. A sales representative does not have the Company's authorization 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 agree any policy based on this application shall not take effect and the Company will have no liability unless and until: a) the policy is issued and accepted by me during the lifetime of the Proposed Insured and, b) the first month's full premium is received by the Company at its corporate office in Windsor, CT during the lifetime of the Proposed Insured. I understand that the completion of this application in no way implies that I will be accepted for insurance coverage.

Fraud Statement: 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.

Insurance products offered by Vantis Life are: NOT deposits, NOT insured by the FDIC/NCUA or any other federal government agency, and NOT obligations of, nor guaranteed by any bank or credit union.

♦ AUTHORIZATION TO RELEASE INFORMATION

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance company, consumer reporting agencies, MIB, Inc. ("MIB") formerly known as the Medical Information Bureau, or any similar organization, institution or person that has records of me or my minor children, my employment, and me or my minor children's health to give any such information to Vantis Life or its reinsurers. I understand that the information released to Vantis Life or its reinsurers will be used to determine my eligibility for the insurance requested. Vantis Life may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of Vantis Life. I authorize Vantis Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any information relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photocopies of it will be valid for two years following the date signed, unless otherwise required by law. The information released to Vantis Life will not be given, sold or transferred to any other person not mentioned above. I understand that I or my authorized representative is entitled to a photocopy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

X _____ _____

Legal Signature of Proposed Insured | Date

X _____ _____

Legal Signature of Owner If Other Than Proposed Insured | Date

Signed at:: _____

City | State

♦ AGENT/PRODUCER CERTIFICATION & SIGNATURE

Replacement Questions: Does the Proposed Insured have existing coverage? ❑ Yes ❑No

Does this sale involve a replacement? ❑ Yes ❑No (if Yes, submit required state forms)

If the Proposed Insured is under age 15, please provide Existing Coverage details for Parents/Guardian & siblings of Proposed Insured:

(total amount in-force)_____

Know Your Customer: Did the Proposed Insured provide identification, i.e. drivers license or green card? ❑ Yes ❑No

Declaration: By signing this application, I certify that information recorded accurately and completely as provided by the applicant on this application and on any accompanying forms and that such forms and disclosures are completed in accordance with applicable laws and Company procedures.

X _____ _____ _____

Vantis Life Insurance Agent Signature | Date | Vantis Life Insurance Agent Printed Name