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

Previous Name

Legal Residence Address

Preferred Phone # Alternate Phone # Best Time to Call

Email Address

Date of Birth Place of Birth (Country/State) Marital Status

SSN / Gov't ID 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 ($)	Date Issued	To Be Replaced	To Be Financed
				☐ Yes. ☐ No.	☐ Yes. ☐ No.
Name of Company	Policy/ID Number	Insurance Amount ($)	Date Issued	To Be Replaced	To Be Financed
				☐ Yes. ☐ No.	☐ Yes. ☐ No.

OWNER

Owner is
Proposed Insured / Individual *(Other than Proposed Insured)* / Trust / Corporation

Name of Owner (Person) Relationship to Proposed Insured SSN / Gov't ID

Name of Owner (Entity) Authorized Signature Name EIN / Gov't ID Date of Trust Agreement

Owner Address Owner Email Address

SECONDARY ADDRESSEE

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

Secondary Addressee Name

Secondary Mailing Address

BENEFICIARY

[Primary Beneficiary Date of Birth % of Benefit Relationship to Insured SSN / Gov't ID

Address Phone Number

Contingent Beneficiary Date of Trust Agreement % of Benefit Relationship to Insured EIN / Gov't ID

Address Phone Number]

QUESTIONS TO THE PROPOSED INSURED

1. Are you a United States citizen? ☐ 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? ☐ Yes. ☐ No.
8. 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 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.
9. Within the next {2 years}, do you plan to travel or reside outside the United States? ☐ Yes. ☐ No.
10. Have you consulted a physician within the past {5 years}? ☐ Yes. ☐ No.
11. Do you have a valid driver's license? ☐ Yes. ☐ No.
12. Within the past {5 years} have you:
    a. had your driver's license suspended or revoked? ☐ Yes. ☐ No.
    b. been convicted of reckless driving or driving under the influence of alcohol or drugs? ☐ Yes. ☐ No.
    c. been convicted of any moving violations? ☐ Yes. ☐ No.
13. Within the past {5 years} have you been subject of any bankruptcy proceedings? ☐ Yes. ☐ No.
14. 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, advised 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. been convicted of any felony? ☐ Yes. ☐ No.
15. Within the past {5 years} have you:
    a. received any kind of disability benefits, workman's compensation or long term care benefits? ☐ Yes. ☐ No.
    b. had an application for health or life insurance, rated up, postponed or declined? ☐ Yes. ☐ No.
16. Have you {ever} been convicted in, or pled guilty to a criminal proceeding or do you have criminal charges pending? ☐ Yes. ☐ No.
17. Within the past {10 years} have you been diagnosed with, consulted a member of the medical profession or been treated 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, elevated cholesterol or any other disorder of the heart, blood vessels or peripheral vascular system? ☐ Yes. ☐ No.
    d. ulcerative colitis, hepatitis, disorder of the esophagus, intestines, liver disorder or any other digestive disorder? ☐ Yes. ☐ No.
    e. diabetes, 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.

QUESTIONS TO THE PROPOSED INSURED (continued)

g. asthma, shortness of breath, chronic bronchitis, chronic obstructive pulmonary disease (COPD), cystic fibrosis, emphysema, sleep apnea or any other respiratory disorder (other than asthma), or any other respiratory disorder? ☐ Yes. ☐ No.

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

i. alzheimer's disease, dementia, organic brain syndrome, cognitive impairment (of any degree), or amyotrophic lateral sclerosis (ALS), anxiety, depression, 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. Have either of your natural parents, or has any sibling been diagnosed with, or died from, cancer, diabetes, heart or kidney disease before the age of {65}? ☐ Yes. ☐ No.

23. Do you currently have a mortgage? ☐ Yes. ☐ No.

24. Are you currently on oxygen for a medical condition, or confined to a nursing facility or assisted living facility? ☐ Yes. ☐ No.

25. 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.

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

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

{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 is
Proposed Insured / Owner *(Other than Proposed Insured)* / Individual *(Other than Proposed Insured)* / Corporation *(Other than Owner)*

Name of Payor

Payor Address

Initial Payment
Payment Mode

Payment Method

Draw Date (Day of the Month)

Card Type

Name of Bank

Amount Paid with Application ($)

Recurring Payment
☐ Same as Initial
Payment Mode

Payment Method

Draw Date (Day of the Month)

Card Type

Name of Bank

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

_____

Authorized Signature

_____

Authorized Signature

_____

Reference #

_____}

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 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} 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.

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.

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION (continued)

Signed this Date City State

Printed Name of Proposed Insured

Signature of Proposed Insured

Signature of Proposed Insured

Signature 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.

Producer Name State License Identification Number

Email Address of Producer Telephone Number of Producer

General Agent ID Facilitating Agent Name Facilitating Agent ID

Producer Signature
Electronically Signed By: