

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Lumico Life Insurance Company

Home Office: [237 E High Street, Jefferson City, MO 65101] Administrative Office: [P.O. Box 83303, Lincoln, NE 68501-3303]

Section 1: Proposed Insur	ed's Personal Informa	tion			
First name	[Middle name]	Last na	me		
Gender (Select one): ☐ Male ☐ Female	of birth (mm/dd/yyyy):	[Birth State & Cou	[Social Security Number]		
Home address (street address, cit	y, state, zip)				
Mailing address (street address, c	ity, state, zip)				
E-mail address:	Phone number:				
[Driver's License Number:]	[State of Issue:]		status (single, couple, single I(ren), couple with child(ren))]		
[Occupation:]		[Are you a United States citizen? ☐ Yes ☐ No; or do you have Permane Resident (Green Card) status? ☐ Yes ☐ No]			
Section 2: Owner (Complete	e only if Owner is different th	an the Proposed Insur	ed		
First name	[Middle name]	Last na			
Relationship to Insured		[Social Security N	umber <mark>]</mark>		
Home address (street address, cit	y, state, zip)				
Mailing address (street address, c	ity, state, zip)				
E-mail address	Phone	e number:]			

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Section 3: Cov	verage ————					
Type [□ 10 year level to □ 15 year level to □ 20 year level to □ 30 year level to	erm erm erm	Coverage Amount \$		ders Dependent Child Accidental Death I Waiver of Premiun		
Initial Payment Am \$	nount					
Dependent Child	Rider					
Coverage Amount \$	t					
First Name		Last Name		ate of birth nm/dd/yyyy):	[Social Se Number]	curity
					1	
Section 4: Oth		ance or annuity contr	acts in force with	this company or an	y other compan	y?
☐ Yes ☐ No	0					
Have you ever had	an application o	or reinstatement requ	est for life, healtl	n or disability insurar	nce declined or I	postponed?
☐ Yes ☐ No	0					
Will the policy that No	you are applyin	g for replace or chan	ge any of life insu	urance policies or an	nuity contract y	ou have? 🛚 Yes
If YES, please	provide details:					
Insurance Company Name Type of Policy		Policy Number		A	Amount	
Section 5: Ber	neficiary Info	ormation				
Primary Beneficia						
Full Name	Address		Date of Birth (mm/dd/yyyy)	[Social Security Number]	Relationship to You	% (total must add to 100%)
Contingent Benef			D . (5)	10 : 10 :	D 1 .: 1:	0/ /
Full Name	Address		Date of Birth	[Social Security	Relationship	% (total must

	(mm/dd/yyyy)	Number]	to You	add to 100%)

Section 6: Proposed Insured Personal and Medical History

[I declare that all of the following statements and answers I provide in this application are true and complete to the best of my knowledge and belief. \square Yes \square No]

best of r	ny knowledge and belief. □ Yes □ No]
	[Many people use tobacco or nicotine products to relax or when out with friends. In the last 12 months, how often have you used a tobacco product (excluding celebratory cigar use less than 4 times a year)?
	☐ Daily ☐ only on the weekends, ☐ once or twice, ☐ I have not used a tobacco product in the last 12 months.]
② _]	[Weight (pounds)] [Height (feet, inches)]
[3]	[In the past 2 years, for any condition (other than childbirth), have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility for greater than 3 days, or have you been diagnosed by a member of the medical profession with a terminal condition (terminal condition means a medical condition resulting from injury or illness that is reasonably expected to result in the drastically limited life span of the Insured within 12 months or less), or have you needed help with dressing, eating, walking or breathing (including the use of oxygen)? Yes No]
[4]	[In the past 5 years have you: pled guilty to or been convicted of a felony or more than 1 misdemeanor, or currently incarcerated, on probation or parole; or pled guilty to or been convicted of driving under the influence or more than 4 moving violations, or received medical treatment or counseling for alcohol or substance abuse, or been advised to reduce consumption of alcohol by a member of the medical profession? Yes No
[5]	 [In the past 5 years, have you (a) received treatment by a member of the medical profession for, or (b) been diagnosed or been advised by a member of the medical profession to seek treatment for, or (c) consulted with a health care provider regarding: (a) Dementia, schizophrenia, attempted suicide or have been hospitalized or missed more than 1 week of work as a result of anxiety, depression, or bipolar disorder? ☐ Yes ☐ No (b) Cirrhosis, Hepatitis C, stroke, brain tumor, leukemia, or cancer? (Answer NO if you ONLY have basal or squamous cell skin cancer) ☐ Yes ☐ No (c) Central Nervous Disorder, Amyotrophic Lateral Sclerosis (ALS), lupus, chronic kidney disease, respiratory disorder, heart or circulatory disorder? (Answer NO if you ONLY have asthma or high blood pressure) ☐ Yes ☐ No (d) Uncontrolled diabetes or diabetes related complications such as hypoglycemia, retinopathy, neuropathy, cerebrovascular or peripheral vascular disease? ☐ Yes ☐ No
[<u>6</u>]	[Have you ever been diagnosed by a member of the medical profession with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No]

Section 7: Payment Options				
Full name and billing address [(if different from the Owner)]				
Payment Frequency (Check One)				
[□ Annual □ Semi-Annual □ Quarterly □ Monthly □ Bi-I	Monthly ☐ Weekly ☐ Bi-Weekly]			
Payment Method				
☐ Pre-authorized check (EFT)]				
[Bank name:] [Bank routing number:] [Bank account number				
[□ Pre-authorized credit card/debit card]				
[□ Visa □ MasterCard □ American Express □ Discover] [Card number of the content	per:] [Expiration date:] [CW:]			
THE PAYOR I authorize Lumico Life Insurance Company to charge my Premiums to my [checking/saving account][or][Credit				
card/Debit card]. This authorization is to remain in effect until I request cancellation.				
Signature	Date			

INSURED DECLARATION AND REPRESENTATION

By signing below, I agree I have read the application, and all statements and answers as they pertain to me, and that these statements and answers are true and complete to the best of my knowledge and belief. I understand the statements and answers in the application are the basis for any policy issued by Lumico Life Insurance Company ("the Company"). No information about these statements and answers will be considered to have been given to the Company unless it is stated in this application. I understand that federal law requires sufficient information to identify the parties to the purchase of a policy and that failure to provide such information could result in the policy not being issued, being delayed, unprocessed or terminated.

I understand and agree that no sales representative has the Company's authority to accept risks or pass on insurability or make, void, waive, or change conditions or provisions of the application, policy or receipt. If prior to the issuance of the policy applied for there is a change in the health of a proposed insured that would require a change to the proposed insured's answers to any questions in this application, any amendments thereto, or to any supplemental applications, prior to the issuance of the policy herein applied for, I will notify the Company as soon as possible of the change. I understand and agree that the Company will have no liability until the policy based upon this application is issued, delivered and accepted by me and the first premium is paid in full while each proposed insured is alive. If all the conditions are not met, the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Insurance Fraud Warning: 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.

Signature			Date	
Signed at:	City	Sta	ite	

[OWNER DECLARATION (Complete only if Owner is different than the Proposed Insured)

I agree that the statements and answers provided within the entire application form are true, complete, and correct to the best of my knowledge and belief. I acknowledge Lumico Life Insurance Company has the right to information sufficient to establish my identity and a valid insurable interest in the [life][lives] of the proposed insured[s].

I have received and read the Consent to Electronic Signature and Electronic Document Delivery.

Signature		Date
Signed at: City	Sta	ate]

AGENT'S STATEMENT To the best of my knowledge and belief, the proposed insured □ does □ does not have any existing life insurance or annuity contract in force or applications pending insuring the proposed insured's life				
To the best of my knowledge and belief, the proposed insured \Box does \Box does not intend to replace or change existing insurance or annuities with this transaction.				
If the proposed insured "does" intend to replace or any required replacement forms.	r change existing insurance or annuities with this transaction, complete			
Signature	Date			
Signed at: City	State			
[Signature	Date			
Signed at: City	State			
Signature	Date			
Signed at: City	State]			