APPLICATION FOR INDIVIDUAL TERM LIFE 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.

I. PROPOSED INSURED:

Name (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Social Security or Tax ID Number:
Current Mailing Address (Number and Street):		
City:	State:	Zip Code:
E-mail Address:		

Cell Phone Number:	Birth State:	Birth Country, if not born in US:

Gender: ☐ Male ☐ Female [☐ I don't identify exclusively as male or female]
[What was your biological sex at birth? ☐ Male ☐ Female]

[Marital Status: ☐ Single ☐ Married [or Civil Union Partner] ☐ Divorced ☐ Widowed
☐ [Common Law Spouse or] Domestic Partner]

1. Do you have a valid driver's license?
☐ Yes [What state is it issued from?: Driver's License number:]
☐ No [Please explain why you don't have a driver's license:]

2. Are you a US or Canadian citizen or permanent resident?
☐ Yes
☐ No

3. What is the purpose of this insurance?
☐ Personal (Family Protection)
☐ Other

II. PRIMARY BENEFICIARY: [Estate of Insured] [Beneficiary will be the Estate of the insured unless another individual is designated in this section.]

Name (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Social Security or Tax ID Number:
Current Mailing Address (Number and Street):		
City:	State:	Zip Code:
E-mail Address:		
Percentage of Benefit:	Relationship to the Insured: ☐ Estate [☐ Spouse [or Civil Union Partner] ☐ Child ☐ Parent ☐ Fiancé ☐ [Common Law Spouse or] Domestic Partner ☐ Other [(please provide relationship) _____]	

III. OWNER: [Name of Insured] [Ownership will be the insured unless another individual is designated in this section.]

[Will you be the owner of this policy? ☐ Yes ☐ No		
[Owner's Name (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Social Security or Tax ID Number:
Current Mailing Address (Number and Street):		
City:	State:	Zip Code:
E-mail Address:		
[Contact Phone (include area code):]	Relationship to the Insured: ☐ Spouse [or Civil Union Partner] ☐ Parent ☐ Fiancé ☐ [Common Law Spouse or] Domestic Partner ☐ Other (please provide relationship)_____]]	

[IV. PAYOR: [Name of Insured] [Payor will be the Insured unless another individual is designated in this section.]

Will you be the payor of this policy? ☐ Yes ☐ No		
[Payor's Name (First, Middle, Last):	Date of Birth (mm/dd/yyyy):	Social Security or Tax ID Number:
Current Mailing Address (Number and Street):		
City:	State:	Zip Code:
E-mail Address:		
[Contact Phone (include area code):]	Relationship to the Insured: ☐ Spouse [or Civil Union Partner] ☐ Parent ☐ Fiancé ☐ [Common Law Spouse or] Domestic Partner ☐ Other (please provide relationship)_____]]	

[V.] COVERAGE APPLIED FOR

Level Premium Term: [☐ 10 Year Term ☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term]	Amount of Insurance: $
[Riders:]	

[VI. BILLING INFORMATION

Premium Payment Frequency: ☐ Monthly [Premium of $_____] ☐ Quarterly [Premium of $_____] ☐ Annually [Premium of $_____]		[Premium Payment Method: ☐ Electronic Funds Transfer (EFT) ☐ Credit Card]	
[Bank Account Owner Name:	Bank Name:	Routing Number:	Account Number:]
[Type of Credit Card:	Name on Credit Card:	Credit Card Number: CVV:	Expiration Date:]
☐ The Billing Address is other than the Current Mailing Address of the Insured			
[Billing Address (Number and Street):			
City:		State:	Zip Code:]

[VII. SECONDARY ADDRESSEE

You may identify a second person to whom we may send policy notices of cancellation, nonrenewal and conditional renewal information. These notices would be in addition to the notices we mail to you. Please indicate below if you do or do not want to have a second person receive any such notices. ☐ I choose to name a Second Addressee (If you choose this option, please provide the name, address and other information below) ☐ I choose not to name a Second Addressee		
Secondary Addressee Name (First, Middle, Last):	Contact Phone (include area code):	
Current Mailing Address (Number and Street):		
City:	State:	Zip Code:]

[VIII.] INSURANCE HISTORY

1. Do you have or have you applied for any other life insurance or annuities? ☐ Yes ☐ No
2. Do you have any agreements in place to assign/sell this policy? ☐ Yes ☐ No

[IX.] FINANCIAL

1. What is your annual pre-tax income?
2.[What is your current employment status: ☐ Employed ☐ Homemaker ☐ Retired ☐ Student ☐ Unemployed ☐ Other] [Are you employed? ☐ Yes ☐ No]
3. Have you filed bankruptcy in the past 5 years? ☐ Yes ☐ No
4. Within the past 12 months have you been unable to work for more than 30 consecutive days due to illness or injury? ☐ Yes ☐ No

[X.] MEDICAL QUESTIONS

1. Within the past 10 years have you been diagnosed or treated by a medical professional for any of the following:
[Please refer to the Additional Information Section for details regarding your affirmative response to the condition(s) below]

Mental, Behavioral or Psychiatric Disorder
Including anxiety, panic disorder, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), depression, manic depressive disorder, bipolar disorder, suicide attempt or gesture, schizophrenia, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), anorexia, bulimia, other

Neurological Disorder
Including muscular dystrophy, parkinson's disease, seizures, paralysis, multiple sclerosis (MS), huntington's disease (chorea), lou gehrig's disease (ALS), alzheimer's disease, dementia, other

Disorder of the Brain and/or Cerebral Blood Vessels
Including stroke, cerebrovascular accident (CVA), transient ischemic attack (TIA), aneurysm, other

Anemia, Blood or Immune System Disorder (other than HIV)
Including anemia, bleeding or clotting disorder (including hemophilia), immune disorder (other than HIV), any other disease or disorder of the blood or immune system

Cancer, Tumor or other Abnormal Growth
Including skin cancer (including basal cell and squamous cell), melanoma, lymphoma, leukemia, tumor, polyp, any other abnormal growth, any other type of cancer

Connective Tissue or Autoimmune Disorder
Including lupus, scleroderma, rheumatoid arthritis, psoriatic arthritis, other

Diabetes, Thyroid or other Endocrine Disorder
Including gestational diabetes, diabetes (other than gestational), impaired glucose tolerance, hypothyroidism, goiter, grave's disease, hyperprolactinemia, hypopituitarism, hyperthyroidism, cushing's disease, addison's disease, parathyroid disease, other

Heart or Circulatory Disorder
Including heart attack (myocardial infarction), chest pain, irregular heart beat (arrhythmia), heart murmur, heart failure, heart valve disorder, cardiomyopathy, coronary artery disease (CAD), peripheral vascular disease, deep vein thrombosis (DVT), neuropathy, other

Lung or Respiratory Disorder
Including sleep apnea, asthma, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, sarcoidosis, shortness of breath (dyspnea), tuberculosis, pulmonary embolism, cystic fibrosis (CF), other

☐ **Yes**
☐ **None of the above**

2. Within the past 5 years have you been diagnosed or treated by a medical professional for any of the following:
[Please refer to the Additional Information Section for details regarding your affirmative response to the condition(s) below]

[High Blood Pressure (Hypertension)]

[High Cholesterol (Hyperlipidemia)]

Muscle, Bone or Joint Disorder
Including arthritis (degenerative or osteoarthritis), degenerative or herniated disc disease, chronic pain, neck/back pain, gout, fibromyalgia, other

Digestive or Gastrointestinal Disorder
Including gastroesophageal reflux disorder (GERD), barrett's esophagus, ulcer, ulcerative colitis, crohn's disease, hepatitis, esophageal varices, cirrhosis of the liver, diverticulosis/diverticulitis, gastrointestinal or rectal bleeding, celiac disease, pancreatitis, other

Bladder, Kidney or Urinary Disorder
Including blood in your urine (hematuria), protein or albumin in your urine, sugar in your urine (glycosuria), polycystic kidney disease, nephritis (glomerulonephritis), kidney failure and/or dialysis, bladder or urinary tract infection (cystitis), other

Genital or Reproductive Disorder
Including [disorder of the ovaries,] disorder of the breast, [pregnancy complications,] [disorder of the prostate,] sexually transmitted disease, other

☐ **Yes**
☐ **None of the above**

3. Have you ever been diagnosed by a medical professional or tested positive for HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)?
☐ Yes
☐ No

4. In the last 5 years, has a medical professional recommended any test (other than HIV), treatment, or consultation that you have not yet completed, or are awaiting results for?
☐ Yes
☐ No

5. Within the past year other than what you've already told us, has a medical professional recommended that you have any diagnostic or screening test?
☐ Yes
☐ No

6. Within the past 5 years, other than what you have already told us, have you:
Had a non-routine consultation with a medical professional
Been diagnosed or treated for any other condition
☐ Yes
☐ None of the above

7. What is your height?	What is your weight?	Has your weight increased or decreased by more than [20] pounds in the past [year]? ☐ Yes ☐ No

Family History

8. Has a biological parent or sibling been diagnosed with or treated for any of the following?
Polycystic kidney disease
Huntington's disease (chorea)
Cancer
Heart disease
Unknown
☐ Yes
☐ None of the above

Habits History

9. [When was the last time you used any nicotine or tobacco product?
[☐] [●] In the past 12 months
[☐] [●] 1-2 years ago
[☐] [●] 2-3 years ago
[☐] [●] 3-5 years ago
[☐] [●] 5 or more years ago
[[☐] [●] Never]]
[Date:_____]

[Which nicotine products do you use or have used] [Which best describes the nicotine product(s) that you use or have used in the past?] If multiple, check all.
[☐] [●] Cigarettes, e-cigarettes, vaporizers
[☐] [●] Pipe tobacco, hookah/water pipe
[☐] [●] Cigars
[☐] [●] Chew or snuff
[☐] [●] Nicotine patch or gum
[☐] [●] Other
[☐] [●] I have never used tobacco products]

[Which best describes the nicotine product(s) that you use or have used in the past?
☐ Cigarettes, Electronic Cigarettes (Vaporizers), Pipe Tobacco, Hookah/Water Pipe, Cigars, Chew or Snuff, Nicotine Patch or Gum, Other nicotine
☐ I have never used tobacco products]

[	In the past 12 months	1-2 years ago	2-3 years ago	3-5 years ago	More than 5 years ago	Never
Cigarettes						

Cigars							
Pipe tobacco							
E-cigarettes, vaporizers							
Chew or snuff							
Hookah/water pipe							
Nicotine patch							
Nicotine gum							
Other nicotine							]

10. Have you used marijuana, CBD or THC in the last 5 years?
☐ Yes
☐ No

11. [Do you consume alcohol?
☐ Yes
☐ No]
[In an average week how many alcoholic beverages do you consume?] [In an average week how many of the following [alcoholic beverages] [drinks] do you consume? [(If none, please indicate "0")]
(a) Wine/Wine Cooler[: average number per week:_____]
(b) Beer[: average number per week:_____]
(c) Cocktails/Mixed Drinks[: average number per week:_____]
(d) Liquor/Shots[: average number per week:_____]
(e) Other[:average number per week:_____]
[[(f)] What type of other drink(s) do you consume?] [(Please provide details in the Additional Information Section)]]]

12. Other than what has already been disclosed, within the past 10 years have you:
Been a member of a self-help group [alcoholics anonymous (AA), narcotics anonymous (NA), gamblers anonymous (GA), etc.]
Been advised by a medical professional to seek treatment or counseling for alcohol or drug use
Had treatment or counseling for alcohol or drug abuse
Been advised by a medical professional to reduce your alcohol intake
☐ Yes
☐ None of the above

13. Within the last 5 years, have you used any non-prescribed controlled or illegal drugs? [cocaine, heroin, amphetamines, barbiturates or hallucinogens, etc.] (other than marijuana)
☐ Yes
☐ No

14. Please provide contact information for your personal physician [including name, city and state, and date last seen]:

[XI.] NON-MEDICAL QUESTIONS

1. Have you in the past 2 years, or do you plan in the next year, to participate in any of the following?: [Please refer to the Additional Information Section for details regarding your affirmative response to the avocation(s) below]

Recreational Aviation
non-commercial aircraft, rotorcraft, helicopter

Air Sports
glider, ultra-light flying, ballooning, blimps, paragliding, hang gliding, skydiving

Motor Sports
land vehicle racing, water vehicle racing

Mountain, Rock, Snow or Ice Climbing

Scuba Diving

Cliff Diving

Other Sport Activities
cave exploration, base jumping, wingsuit flying, boxing (kickboxing, UFC, MMA), heliskiing, bungee jumping

☐ **Yes**

☐ **None of the above**

2. Do any of these apply to you: I've been convicted of a felony or misdemeanor I am currently on parole or probation I have charges currently pending I am currently in jail ☐ Yes ☐ None of the above
3. Within the past 5 years do any of the following apply: Had your license suspended or revoked Pled guilty or been convicted of a DUI, driving without a license, or reckless driving Pled guilty or been convicted of any other moving violations ☐ Yes ☐ None of the above
4. Are you or have you agreed to become a member of the armed forces including the National Guard or Reserves? ☐ Yes ☐ No
5. Are you planning to travel or live outside of the US or Canada within the next 2 years? ☐ Yes ☐ No

[XII.][ADDITIONAL INFORMATION SECTION]

[

]

[FOR EFT PAYMENT ELECTION:] [AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER - By signing this application, I authorize Greenhouse Insurance (the Company) to initiate a monthly, quarterly, or annual withdrawal from the specified account of the financial institution indicated, for the purpose of meeting premium payment obligations. I understand: (1) No premium is considered paid until each debit is accepted by the financial institution. (2) Any debit not honored may be subject to a return fee from the financial institution. (3) For any debit not honored, the Company may attempt to debit the account again up to three days later for the amount due. (4) The Company will not incur liability as a result of a debit that is not honored by the financial institution. (5) The [insured/owner/payor] or the Company may terminate this agreement at any time by written notification from one party to the other party.]]

[FOR CREDIT CARD ELECTION:] [AUTHORIZATION FOR CREDIT CARD PAYMENT - By signing this application, I authorize Greenhouse Insurance to initiate a monthly, quarterly, or annual charge to the credit card shown on the application for the purpose of meeting premium payment obligations. I agree not to contest these charges upon approval of this credit card transaction.]

The undersigned declares that all answers and statements in this application are full, true and complete to the best of their knowledge and belief, and understands that all answers and statements in this application will be relied upon by Greenhouse Insurance (the Company) to determine insurability and to issue the policy. No information will be considered given to the Company unless it is stated in the application; and a misrepresentation may void the policy during the Contestable Period.

This policy will take effect when the application is: approved by the Company; the initial premium is paid; the insured is alive at the time of policy delivery; and the answers and statements in the Application remain full, true and complete at the time of policy delivery.

I authorize any licensed physician, medical practitioner, hospital, other health care provider, insurance or reinsurance company, consumer reporting agency, Social Security Administration or state motor vehicle agency other governmental agency, employer, MIB, Inc., pharmacy or pharmacy benefit manager, consumer reporting agency or other organization or person to give or release any personal (medical or non-medical) information about me or my mental or physical health to the Company and/or its reinsurers to determine my eligibility for life insurance coverage, including my entire medical record without restriction if requested and non-medical information, including financial, credit history, credit report, recreational activities, occupation, foreign travel and driving record to the Company, its reinsurer or any authorized third-party administrator or service providers. The Company may disclose such information to its reinsurers and the MIB, Inc. The Company or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted.

I also authorize the Company, its reinsurers, or authorized third-party administrator or service provider to make a brief report of my personal health information to the MIB. I authorize the Company to obtain an investigative consumer report on me, if required.

This authorization is valid for a period of 24 months following the date of my signature below, or a shorter period if required by law, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original.

I understand that I will receive a copy of this authorization upon request.

The undersigned acknowledges receipt of Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and/or Notice of Information Practices (if applicable).

Signature of Proposed Insured[/Owner]: _____

Signed at (city, state):_____ Date: _____

[Signature of Owner: _____]

[Signed at (city, state):_____ Date: _____]