Gerber Life Insurance Company
Home Office: White Plains, New York
Administrative Office: 445 State Street, Fremont MI 49412
www.gerberlife.com

I. PERSONAL INFORMATION

APPLICATION FOR: INDIVIDUAL LIFE INSURANCE

PROPOSED INSURED: (Give full legal name)

First Name_____ Last Name_____ Middle Initial_____

Gender ☐ Male ☐ Female Date of Birth_____ (Month Day Year) Place of Birth (State/Country)_____

Social Security Number_____ Driver's License Number_____ State_____

Legal Residence Address_____ City_____ State_____ Zip_____

Email Address_____

Primary Phone_____ Cell: ☐ Yes ☐ No Secondary Phone_____ Cell: ☐ Yes ☐ No

Occupation(s)_____ Employer or Business Name_____

Annual Earned Income $_____ How long with current employer?_____ Type of business where currently employed_____

Are you a United States citizen or do you have Permanent Legal Resident (Green Card) status? ☐ Yes ☐ No

COVERAGE APPLIED FOR:

☐ Whole Life ☐ Level Term Period (select one) ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ 30 Years

Face Amount Applied For (must be from $25,000–$1,000,000) $_____,000

OWNERSHIP:

Will someone other than the insured own the policy being applied for? ☐ Yes ☐ No

Relationship: _____

BENEFICIARY INFORMATION:

Primary Beneficiary(ies)_____ Relationship to the Insured_____

Contingent Beneficiary(ies)_____ Relationship to the Insured_____

II. AUTHORIZATION TO OBTAIN INFORMATION

I authorize any insurance company, employer, physician, medical professional, hospital, medical facility, pharmacy, pharmacy benefit manager, consumer reporting agency, MIB, Inc. (MIB), or any other person or organization that has any record of information about me to give to Gerber Life Insurance Company, its reinsurers or its authorized representatives, (together, the Company) information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including drug and alcohol treatment information, prescription history records, or other information the Company requires to determine insurability, eligibility for benefits, investigate claims, or support the business operations of the Company related thereto. I authorize Gerber Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB. I further authorize the sources listed above except MIB to give such information to a consumer reporting agency acting on behalf of Gerber Life Insurance Company. Gerber Life Insurance Company may release information obtained by this Authorization to its reinsurers, to MIB, to other insurers with whom I have policies or to whom I may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me, or as may otherwise be lawfully required.

I have received a copy of the Notice of Insurance Information Practices. My authorized representative or I may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health or other privacy related information from the Company from re-disclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I understand that a copy of this authorization will be provided, upon request, to me or a person authorized on my behalf. I understand that disclosure of information to the Company may subject the information to re-disclosure in accordance with the Company's privacy policy and MIB rules. Any such re-disclosed information will be subject to the protections of Montana law section 33-19-306, but may no longer be protected by federal rules governing privacy and confidentiality. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Gerber Life Insurance Company at the address above.

X Signature of Proposed Insured_____ Date_____

X Signature of Policyowner (if other than Proposed Insured)_____ Date_____

Signed at (City, State)_____

III. QUESTIONS OF THE PROPOSED INSURED

Height_____(Feet) _____(Inches) Weight_____(Pounds) Has your weight changed by more than 10 pounds in the past year?..... ☐ Yes _____(Pounds) ☐ No

In the past 36 months, have you smoked or used tobacco in any form?..... ☐ Yes ☐ No

MEDICAL AND BACKGROUND QUESTIONS:

1. To the best of your knowledge and belief, has the Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:

a. Heart disorder, including a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), chest pain, hypertension (high blood pressure), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (TIA or mini-stroke) or rheumatic fever?..... ☐ Yes ☐ No

b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders (excluding HIV), elevated cholesterol, liver disease, hemophilia, kidney disease (other than kidney stones), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, bladder or prostate, other intestinal or digestive tract disease or pancreatitis?..... ☐ Yes ☐ No

c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes?..... ☐ Yes ☐ No

d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation, including Down's Syndrome, multiple sclerosis (MS), muscular dystrophy (MD), Parkinson's disease, amyotrophic lateral sclerosis (ALS), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?..... ☐ Yes ☐ No

e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COPD), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (including lupus or scleroderma)?..... ☐ Yes ☐ No

f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?..... ☐ Yes ☐ No

g. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?..... ☐ Yes ☐ No

h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?..... ☐ Yes ☐ No

i. Any disease or disorder of the eyes, ears, nose or throat?..... ☐ Yes ☐ No

j. Any other illness or injury requiring medical attention or blood transfusions?..... ☐ Yes ☐ No

2. To the best of your knowledge and belief, has the Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age 60?..... ☐ Yes ☐ No

3. To the best of your knowledge and belief, has the Proposed Insured ever been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or antibodies to human T-lymphotropic virus type III (HTLV)?..... ☐ Yes ☐ No

4. During the past 5 years, has the proposed insured:

a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?..... ☐ Yes ☐ No

b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens, or any other controlled substance not prescribed by a physician?..... ☐ Yes ☐ No

c. Been treated by a physician or been advised by a physician to seek treatment for drug or alcohol use?..... ☐ Yes ☐ No

d. Been advised to have any test (except HIV tests), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed or for which results have not been received ?..... ☐ Yes ☐ No

e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests or urine tests (other than AIDS-related blood tests)?..... ☐ Yes ☐ No

f. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined or had insurance renewal or reinstatement refused?..... ☐ Yes ☐ No

g. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ..... ☐ Yes ☐ No

5. a. To the best of your knowledge and belief, has the Proposed Insured ever had any disorder of any genital or reproductive organ? .... ☐ Yes ☐ No

b. To the best of your knowledge and belief, is the proposed insured currently pregnant?..... ☐ Yes ☐ No

6. a. During the past 5 years, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or pled "guilty" to driving under the influence (OWI/DUI/DWI) or to more than 3 moving violations?..... ☐ Yes ☐ No

b. During the past 5 years, has the Proposed Insured been convicted of a felony, or been on probation/parole, or currently have charges pending?..... ☐ Yes ☐ No

7. During the next 12 months, does the Proposed Insured contemplate residence or travel outside of the U.S.A.?..... ☐ Yes ☐ No

8. Does the Proposed Insured belong to or intend to join the National Guard or Military?..... ☐ Yes ☐ No

9. **a.** Within the past 5 years has the Proposed Insured flown other than as a fare-paying passenger, or is the Proposed Insured contemplating or planning to fly, as a pilot, crew member or student?..... ☐ Yes ☐ No

b. Within the past 5 years has the Proposed Insured participated in, or contemplating or planning participation in any hazardous sport or activities?..... ☐ Yes ☐ No

ADDITIONAL INFORMATION

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_____

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OTHER COVERAGE

Do you have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending?..... ☐ **Yes** ☐ **No**
If "Yes", please complete below.

Company Name_____**City, State**_____
Face Amount_____ **Month/Year Issued**_____ **Is Coverage to be Replaced?**..... ☐ **Yes** ☐ **No**

Company Name_____**City, State**_____
Face Amount_____ **Month/Year Issued**_____ **Is Coverage to be Replaced?**..... ☐ **Yes** ☐ **No**

If this policy is issued, will any other life, accident or health insurance or annuity be cancelled, terminated, lapsed or not renewed? ... ☐ **Yes** ☐ **No**

RIDERS

Would you like to purchase:

(a) Waiver of Premium Rider?..... ☐ **Yes** ☐ **No**

(b) Guaranteed Insurability Benefit Rider?..... ☐ **Yes** ☐ **No**

IV. ACKNOWLEDGEMENT OF INFORMATION PROVIDED

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Other than as stated in any conditional receipt, any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

X **Signature of Proposed Insured**_____**Date**_____

X **Signature of Policyowner (if other than Proposed Insured)**_____**Date**_____

Signed at (City, State)_____

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PRODUCER CERTIFICATION Must be Completed by Producer if applicable

To the best of your knowledge,

1. Does the Proposed Insured have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending? (If Yes, complete appropriate replacement forms)..... ☐ Yes ☐ No
2. Will the coverage applied for replace any life insurance or annuity coverage now in force or pending on the life of the Proposed Insured? (If Yes, complete appropriate replacement forms)..... ☐ Yes ☐ No

Is this a 1035 Exchange? ..... ☐ Yes ☐ No

Is this an internal term conversion? ..... ☐ Yes ☐ No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein ..... ☐ Yes ☐ No

Agent ID_____Date_____

X Signature of Licensed Agent_____Printed Name of Licensed Agent_____

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 a company, MIB, upon request, will supply such company with the information about you 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 (TTY 866-346-3642). If you question the accuracy of the 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.

Gerber Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MIB-08

Your Rights under the Fair Credit Reporting Act

Depending on the size of the policy applied for, we may request that an investigative consumer report about the Proposed Insured be given to us. It will be conducted by a national organization skilled in obtaining information about people. A credit report may be requested in connection with this application to determine eligibility of insurance or premium to be charged.

The kind of information we may be seeking includes such facts as residence verification, marital status, occupation, general reputation, personal characteristics and mode of living. It will be obtained through personal interviews with the Proposed Insured's friends, neighbors, associates and other acquaintances. Inquiries will not be directed toward determining the Proposed Insured's sexual orientation.

The Proposed Insured, upon written request, will be informed whether or not an investigative report was requested, and if a report was ordered, the name and address of the Consumer reporting agency. A copy of this report is available to the Proposed Insured upon request.

To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

Benefits, Exclusions and Limitations

No physical exam is necessary in most cases. Coverage is dependent on answers to health questions, and a physical is necessary for applicants age 51 or older or applying for more than $300,000. If the insured dies by suicide within two years from the issue date, the only amount payable will be the premiums paid for the policy, less any debt against the policy.

Benefit amounts are subject to Gerber Life insurance limits.

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Payment of benefits under the term life policy or whole life policy is the obligation of, and is guaranteed by, Gerber Life Insurance Company. Guarantees are based on the claims paying ability of Gerber Life.

Term Life Policy Form LTL-11-MT

Whole Life Policy Form HWLP-13-MT