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

I. PERSONAL INFORMATION

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

Secondary Addressee and Address_____

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**

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, consumer reporting agency, MIB, Inc., 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, 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 reinsurer to make a brief report of my personal health information to MIB, Inc. (MIB). I further authorize the sources listed above except MIB, Inc. 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 or 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I have received a copy of the Notice of Insurance Information Practices. I or my authorized representative 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 information 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, Inc. rules. 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 or Applicant)_____ 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 tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?..... ☐ 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 been diagnosed or treated by a member of the medical profession for 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. Does the Proposed Insured belong to or, within the next 2 years, intend to join the National Guard or Military?..... ☐ Yes ☐ No
8. a. Within the past 2 years has the Proposed Insured flown other than as a fare-paying passenger, or, within the next 2 years 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 in the next 2 years contemplate or plan to participate in scuba diving, skin diving, sky diving/parachuting, hang gliding, ballooning, bungee jumping, motorcycle racing, mountain climbing or cave exploration? ..... ☐ Yes ☐ No

ADDITIONAL INFORMATION

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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 or Applicant)**_____**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 FL License ID_____ **Date**_____

X **Signature of Licensed Agent**_____ **Printed Name of Licensed Agent**_____