FINAL EXPENSE

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Proposed Insured _____ (First) (Middle) (Last)
Address (No. & Street)_____
City State Zip Code

Telephone interview completed ☐ Yes ☐ No
_____ Phone _____ Best time to call ☐ am ☐ pm
E-mail Address

☐ Male ☐ Female	Date of Birth	Age	State of Birth	Social Security Number	Height	Weight lbs

Owner: Name_____Relationship_____SS#_____
Address

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: _____ **Face Amount of Insurance $**_____
☐ Immediate Death Benefit
☐ Graded Death Benefit (Percentage of Face Amount)
☐ Return of Premium Death Benefit

☐ Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available.

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No

Rider: ☐ Grandchild/Great Grandchild Coverage ____ Number of Children Applying ____ Units ☐ Other _____ Automatic Premium Loan
☐ Child Rider* ☐ Units ☐ ADB* Amt $ (*not available on Return of Premium Death Benefit) Elected? ☐ Yes ☐ No

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date
☐ Other _____ Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem
☐ Collected $

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date:

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☐ No
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☐ No

Company
Policy # Amount of Coverage $

Physician Name: City/State: Phone:

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a nursing facility, a bed, or a wheelchair due to chronic illness or disease, currently using oxygen equipment to assist in breathing, receiving Hospice Care or home health care, or had an amputation caused by disease, or do you currently have any form of cancer (excluding basal cell skin cancer) diagnosed or treated by a medical professional, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ☐ Yes ☐ No
2. Have you had or been medically advised to have an organ transplant or kidney dialysis, or have you been medically diagnosed as having congestive heart failure (CHF), Alzheimer's, dementia, mental incapacity, Lou Gehrig's disease (ALS), liver failure, respiratory failure, or been diagnosed by a medical professional as having a terminal medical condition or end-stage disease that is expected to result in death in the next 12 months? ☐ Yes ☐ No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. Have you ever been medically diagnosed or treated for complications of diabetes, including insulin shock, diabetic coma, retinopathy (eye), nephropathy (kidney), neuropathy (nerve damage/pain), or used insulin prior to age 50? ☐ Yes ☐ No
5. Have you ever been medically diagnosed, treated or taken medication for renal insufficiency, kidney failure, chronic kidney disease, or more than one occurrence of cancer in your lifetime (excluding basal cell skin cancer)? ☐ Yes ☐ No
6. Within the past 2 years have you had any diagnostic testing (excluding tests related to Human Immunodeficiency Virus (HIV)), surgery, or hospitalization advised by a medical professional which has not been completed or for which the results have not been received? ☐ Yes ☐ No
7. Within the past 2 years have you:
   a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cardiomyopathy, systemic lupus (SLE), cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ☐ Yes ☐ No
   b. had a heart attack or aneurysm, or had or been medically advised to have any type of heart, brain or circulatory surgery (including, but not limited to a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ☐ Yes ☐ No
   c. been medically diagnosed, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? ☐ Yes ☐ No
   d. used illegal drugs, abused alcohol or drugs, had or been recommended by a medical professional to have treatment or counseling for alcohol or drug use or been advised to discontinue use of alcohol or drugs? ☐ Yes ☐ No

If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.

8. Within the past 3 years have you been medically diagnosed or treated, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ☐ Yes ☐ No
   b. or taken medication for any form of cancer (excluding basal cell skin cancer), emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, or liver disease? ☐ Yes ☐ No
   c. paralysis of two or more extremities or cerebral palsy, multiple sclerosis, seizures, Parkinson's disease or muscular dystrophy? ☐ Yes ☐ No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

Children listed as an exception are excluded from the appropriate Child Rider Coverage. Exceptions are:_____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice, the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Signed at _____ Date of Application _____

CITY STATE MONTH DAY YEAR

_____ _____

SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

Does the proposed insured have any existing life insurance or annuity contract? ..... ☐ Yes ☐ No

Is the proposed insurance intended to replace or change any existing life insurance or annuity? ..... ☐ Yes ☐ No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable. AGENT'S REMARKS:_____

_____ _____ _____ _____

AGENT'S PRINTED NAME DATE AGENT'S PRINTED NAME DATE

Agent _____ No: _____ % _____ Agent _____ No: _____ % _____

SIGNATURE SIGNATURE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____ Account Holder_____

Financial Institution_____ Address_____

Transit/ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)_____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Occidental Life Insurance Company of North Carolina, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of_____the sum of $_____as first payment on this application.

Date_____Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

NOTICE
Printed in compliance with Public Law 91-508

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Occidental Life Insurance Company of North Carolina, 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 life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Occidental Life Insurance Company of North Carolina, 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, Inc. may be obtained on its website at www.mib.com.

AMERICAN-AMICABLE GROUP OF COMPANIES
WACO, TEXAS

IN LIEU OF SCANNED PHYSICAL VOIDED CHECK
FOR BANK DRAFT AUTHORIZATION

Insured Printed Name: _____

Payor Printed Name: _____

To ensure the accuracy of your provided bank account information and to reduce the occurrences of returned drafts, we've asked you to re-verify the banking information provided during the application process.

Your electronic signature below reaffirms you were given the opportunity to view the account information entered and validate accuracy.

PAYOR SIGNATURE (As on Financial Institution Records)

X_____

DATE SIGNED: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Occidental Life Insurance of North Carolina (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: Any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave, Waco TX 76701.

7. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

8. This authorization will expire 24 months after the date signed.

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

REQUIRED DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount may not be enough to cover your medical, nursing home or other bill. You may use the money you receive from this product for any purpose. Unlike conventional life insurance proceeds, accelerated benefits payable under this product rider COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

Receipt of accelerated benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that you own a rider with an accelerated benefit product may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

The Terminal Illness Accelerated Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 24 months. Upon receipt of proof satisfactory to the Company of the Insured's reduced life expectancy and written consent of any assignee or irrevocable beneficiary we will pay an accelerated benefit. It will be paid in a lump sum. It is payable only once.

The Benefit to be paid will be reduced by an Actuarial Adjustment Factor. There is no administrative charge. We will return to you a proportionate amount of any premium paid beyond the date any Benefit under this Rider is paid. Payment of the Benefit will reduce the Death Benefit proceeds by the amount of the Benefit paid under the Rider. Any portion remaining after reduction of the death benefit due to payment of any acceleration-of-life-insurance benefit will be paid upon the death of the Insured. The Cash Value, the amount available for loans and the premium, excluding the Policy fee, for the Policy will decrease in proportion to the amount of Benefit paid. Continued payment of the reduced premium is necessary for the Policy to remain in force. If the entire Death Benefit is paid, then the Policy will terminate with no further value.

I have received a copy of this Disclosure Statement.

Applicant:_____ Date:_____

I certify that this Disclosure Statement has been presented to the applicant.

Agent:_____ Date:_____

1 Copy - Applicant / 1 Copy - Home Office

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
PO Box 2549 Waco, Texas 76702-2549

Addendum to Application for COVID-19

Proposed Insured's Name (Please Print):_____

1. **Within the past 12 months**, have you been advised by a medical professional to be quarantined, for any period of time for the novel coronavirus (COVID-19)?..... ☐ Yes ☐ No

2. **Within the past 12 months**, have you been treated for, examined for, diagnosed with, or tested positive for the novel coronavirus (COVID-19) by a medical professional?..... ☐ Yes ☐ No

3. **Within the past 30 days**, have you been advised by a medical professional to get specified medical care (such as any diagnostic testing or hospitalization) which was not completed; as result of fever, cough, shortness of breath, fatigue (excluding HIV/AIDS)? ..... ☐ Yes ☐ No

This Addendum to Application amends and is made a part of my individual life insurance application. To the best of my knowledge and belief, all answers and statements contained in this application are true, complete, and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy.

Fraud Notice: Any person who knowingly presents a false statement in application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at_____ Application Date_____
(City and State)

Signature of Proposed Insured_____

Signature of Owner (If other than Proposed Insured)_____