DemoLife LIFE INSURANCE COMPANY
Individual Whole Life Insurance Application Part A

Home Office: 2700 Commerce Street Suite 1000, Dallas, TX 75226 Administrative Office: 2700 Commerce Street Suite 1000, Dallas, TX 75226
"Company," "We,""Our," and "Us" all refer to DemoLife. Unless otherwise stated, "You" refers to the Proposed Primary Insured.

1. PROPOSED PRIMARY INSURED PERSONAL INFORMATION

Legal First Name	Middle Name	Legal Last Name	Suffix	Gender
Christopher	Robert	Smith	BTE	☑ Male ☐ Female

U.S. Social Security Number/ITIN	Date of Birth (mm/dd/yyyy)	Place of Birth (State/Territory, Country)
*****2222	10/29/1990	DE

Physical Residential Address (No P.O. Boxes)	Apartment/Unit
1618 Texas Ave	

City	U.S. State/Territory	Zip Code	Country
Houston	KY	77003	USA

U.S. Mailing Address (if different from physical address)

Phone Number	Email Address
☐ Home ☑ Mobile 585-455-5555	christopher.smith@example.com

2. COVERAGE ELIGIBILITY

A. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- ☐ A condition requiring a defibrillator
- ☐ Alzheimer's Disease, Dementia, memory loss, or mental incapacity
- ☐ Amputation, not due to trauma
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Cerebral Palsy
- ☐ Cystic or Pulmonary Fibrosis
- ☐ Down Syndrome
- ☐ Huntington's Disease
- ☐ Metastatic cancer, recurrent cancer, or cancer of multiple sites
- ☐ Organ transplant recipient
- ☐ Sickle Cell Anemia
- ☑ None of the above

B. Are you currently:

- ☐ Bedridden
- ☐ Incarcerated or on probation or parole due to a conviction or guilty plea
- ☐ Receiving hospice, palliative, or home health care
- ☐ Residing in a nursing home, assisted living or long-term care facility
- ☑ None of the above

	Yes	No
C. Has a member of the medical profession indicated that your life expectancy is 12 months or less, or recommended you be added to a transplant list?	☐	☑
D. In the past 2 years, have you attempted suicide?	☐	☑

3. PERSONAL HISTORY

A. Height (feet and inches): 6 0

B. Current Weight (pounds): 180

C. When was the last time you used tobacco or a nicotine product (examples may include cigarettes, e-cigarettes, vape(s), pipe, hookah/water pipe, chewing tobacco, smokeless tobacco, cigars, nicotine patch or gum)?

☐ Within the last 12 months ☐ 13-24 months ☐ 25-36 months ☐ Over 36 months ☑ I have never used

	YES	NO
D. In the past 2 years, have you been convicted of or pleaded no contest to reckless driving or operating a vehicle while impaired (DWI/OWI/DUI)?	☐	☑
In the past 2 years, have you been convicted of or pleaded no contest to a felony or do you have such charges currently pending against you?	☐	☑
In the past 2 years, have you used narcotics, barbiturates, amphetamines, hallucinogens, heroin, opiates, cocaine, or any habit forming drugs, except as prescribed by a member of the medical profession?	☐	☑
In the past 2 years, have you received or been advised to seek medical treatment or counseling for the use of, or been advised to discontinue the use of, alcohol or drugs by a member of the medical profession or joined an organization for dependence or abuse?	☐	☑

4. MEDICAL HISTORY

A. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: (select all that apply)

- ☐ Cancer, excluding basal cell carcinoma
- ☐ Congestive heart failure (CHF) or cardiomyopathy
- ☐ Cirrhosis, liver failure, or chronic pancreatitis
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Severe asthma or COPD, including Emphysema and chronic bronchitis
- ☑ None of the above

B. In the past 2 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: (select all that apply)

- ☐ Diabetes with any of the following: insulin treatment, peripheral vascular disease, neuropathy, retinopathy, or kidney disease
- ☐ Inpatient treatment as a result of a mental health disorder
- ☐ Irregular heart beat, atrial fibrillation, coronary artery disease (CAD), angina (cardiac chest pain)
- ☐ Liver disease or disorder or Hepatitis, excluding Hepatitis A
- ☑ None of the above

C. In the past 1 year, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: (select all that apply)

- ☐ Cardiac surgery (examples may include pacemaker, stent, valve, bypass, angioplasty)
- ☐ Heart attack
- ☐ Kidney (renal) failure and/or a condition requiring dialysis
- ☐ Prescribed supplemental oxygen
- ☐ Stroke/TIA/CVA
- ☑ None of the above

	YES	NO
D. Have you ever been diagnosed, tested positive for, or been given medical advice by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (AIDS virus)?	☐	☑
In the past 12 months, have you been confined to a wheelchair for assistance (except in the case of a temporary condition immediately following injury or medical treatment not to exceed 3 months time)?	☐	☑
In the past 12 months, have you spent 2 or more nights in the hospital (excluding childbirth)?	☐	☑
In the past 6 months, have you been advised by a member of the medical profession to have any tests, surgery, or hospitalization (except for those related to HIV or AIDS), which have not been completed, or are you waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	☐	☑
In a typical week, do you perform any intentional physical activity for at least 10 consecutive minutes (examples may include yard work, walking, exercising, or playing sports)?	☑	☐

5. U.S. CITIZENSHIP

Are you a U.S. citizen?

☑ Yes ☐ No

6. OTHER INSURANCE/REPLACEMENTS

	Yes	No
Do you have any existing or pending life insurance or annuities with any company (excluding employer-provided and group coverage)?	☑	☐

What is the name of the insurance company? Academy Life Insurance Company
What is the policy number? A123456
How much coverage (also known as face amount) does the policy provide? $50,000.00
Is the coverage being discontinued, replaced or changed? ☑ ☐

What is the name of the insurance company? _____
What is the policy number? _____
How much coverage (also known as face amount) does the policy provide? _____
Is the coverage being discontinued, replaced or changed? ☐ ☐

What is the name of the insurance company? _____
What is the policy number? _____
How much coverage (also known as face amount) does the policy provide? _____
Is the coverage being discontinued, replaced or changed? ☐ ☐

7. Supplemental Questions

How many days per week do you perform physical activity? (0 days, 1 day, 2 days, 3 days, 4 days, 5 days, 6 days, 7 days)

5 days

8. AUTHORIZATION AND SIGNATURE

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and complete to the best of my knowledge and belief. I agree (A) this application shall consist of the Individual Life Insurance Application, the Individual Life Insurance Application - Personal History, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Producer does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the Owner must have personally received and accepted the policy during the lifetime of each Insured and there must have been no change in the insurability of any Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete. Unless otherwise stated, the undersigned Insured is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, pharmacy and pharmacy benefit managers, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, LLC ("MIB"), consumer reporting agency, data aggregator, or any other organization, institution or person, that has any records or knowledge of me or my health/fitness, finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. This may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization. I also understand that any credit reporting agency contacted in connection with this authorization may retain and use any information provided about me to the credit reporting agency to the extent that the information is in addition to or more current than the information currently held by such credit reporting agency, and do consent to such use of my information.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice. This authorization will be valid for 30 months, or the period permitted by applicable law in the state where the policy is delivered or issued for delivery, if shorter. Information released shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force. I understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate contestability and eligibility for benefits, the policy's continuation or replacement, the policy's reinstatement, or to contest a claim under the policy.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Owner or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

The **USA PATRIOT ACT** requires all financial institutions to obtain, verify, and maintain information that identifies each person who opens a new account with the Company, or assumes ownership of an existing policy or contract. To meet this federal obligation, we will ask for your name, address, date of birth, or articles of incorporation or similar documents and other information, including a driver's license or other government-issued identification that will allow us to verify your identity. This process may include the use of third-party sources to verify the information provided.

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 of Proposed Insured	Date	City	U.S. State/Territory
Christopher R Smith	10/29/2025	Houston	KY

Signature of Applicant/Owner (If other than Proposed Insured)	Date	City	U.S. State/Territory
NA	NA	NA	NA

Print Producer Name	Producer Number	Producer Signature
Nathan Osborn	AUTOAGENT-TPL	Nathan Osborn

TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g. a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding, or the IRS has notified me I am no longer subject to backup withholding, or I am not subject to backup withholding because I am exempt; and (3) I am a U.S. person (U.S. citizen/legal resident). If not a U.S. person I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this cerftification. You must cross out item (2) if you are currently subject to backup withholding.

The statements and answers given on this application are honest and true to the best of my knowledge and belief.

☑ I confirm

NOTICE OF DISCLOSURE

Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics, and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any: Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of 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 (ftc.gov). The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company, or its reinsurers, may also release information in 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 mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to: DemoLife Life Insurance Company, Attn: Director of Underwriting, 2700 Commerce Street Suite 1000 Dallas, TX 75226.