

**DemoLife LIFE INSURANCE COMPANY** Individual  
Whole Life Insurance Application Part B

**Demo Life**

**HomeOffice:** 2700 Commerce Street, TX 75226    **AdministrativeOffice:** 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.BENEFICIARIES

Total between all primary beneficiaries must equal 100%. Total between all contingent beneficiaries must equal 100%.

Primary First & Last Name Bene Primo	Date of Birth (mm/dd/yyyy) 10/10/1901	Phone Number	Relationship SPOUSE	Benefit % 100%
U.S. Mailing Address		U.S. Social Security Number/ITIN		
<input type="checkbox"/> Primary First & Last Name <input type="checkbox"/> Contingent	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
U.S. Mailing Address		U.S. Social Security Number/ITIN		
<input type="checkbox"/> Primary First & Last Name <input type="checkbox"/> Contingent	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
U.S. Mailing Address		U.S. Social Security Number/ITIN		
<input type="checkbox"/> Primary First & Last Name <input type="checkbox"/> Contingent	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
U.S. Mailing Address		U.S. Social Security Number/ITIN		
<input type="checkbox"/> Primary First & Last Name <input type="checkbox"/> Contingent	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
U.S. Mailing Address		U.S. Social Security Number/ITIN		

### 2.PAYMENT OPTIONS

Choose the premium payor, payment type and mode, and complete the Payment Authorization form.

Premium Payor:  Proposed Primary Insured  Owner  Other (if chosen, complete Premium Payor Supplement)

Payment Type:  Bank Draft  Credit/Debit Card  Social Security Benefits Billing  Direct Bill

Payment Mode:  Annual  Semi-Annual  Quarterly  Monthly

### 3. OWNER

Complete this section only if the Owner is not the Proposed Primary Insured.

Legal First Name NA	Middle Name NA	Legal Last Name NA	Suffix NA	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
U.S. Social Security Number/ITIN NA	Date of Birth (mm/dd/yyyy) NA		Place of Birth (State/Territory, Country) NA	
Physical Residential Address (No P.O. Boxes) NA		Apartment/Unit NA		
City NA		U.S. State/Territory NA	Zip Code NA	Country NA
Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Mobile NA		Email Address NA		

Owner's relationship to Proposed Primary Insured

Spouse  Child  Parent  Grandparent  Domestic Partner  Other \_\_\_\_\_

Are you a U.S. citizen

Yes  No →

If no, are you a valid U.S. permanent resident  
(green card holder)?  Yes  No →

If yes, does your green card expire within the next  
90 days  Yes  No

#### 4. SECONDARY ADDRESSEE

Complete this section if you would like to list an additional person to receive copies of notices and letters regarding possible lapses in coverage.

Legal First Name	Middle Name	Legal Last Name	Suffix	
U.S. Mailing Address	City	U.S. State/Territory	Zip Code	Country
Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Mobile	Email Address			

#### 5. PRODUCT DETAILS

Product Name	Coverage Amount	(This is the amount of life insurance coverage you are applying for.)	Planned Premium Amount
DemoLife Final Expense	\$50,000.00		\$109.48
Automatic Premium Loan (subject to policy loan provisions): <input type="checkbox"/> Elect <input checked="" type="checkbox"/> Do Not Elect			

**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 Osborne	