[redacted]33
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Application for Accident Insurance

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

Name *First* *Middle* *Last* — Date of Birth *(MM/DD/YYYY)* — Age [redacted]

Social Security No. [redacted] — Gender at Birth ☐ Male ☒ Female

Home Address *Street Address* *City* *State* *ZIP+4* [redacted]

Preferred Phone No. [redacted] — E-mail [redacted]

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident status? ..... ☒ Yes ☐ No

2. OWNER — Complete if different from the Proposed Insured.

Name *First* *Middle* *Last* — Date of Birth *(MM/DD/YYYY)* / /

Social Security No. — Relationship to Insured — E-mail

Home Address *Street Address* *City* *State* *ZIP+4*

3. SPOUSE AND CHILDREN INFORMATION

Spouse:	Name	*First*	*Middle*	*Last*	Date of Birth *(MM/DD/YYYY)* / /
Child No. 1:	Name	*First*	*Middle*	*Last*	Date of Birth *(MM/DD/YYYY)* / /
Child No. 2:	Name	*First*	*Middle*	*Last*	Date of Birth *(MM/DD/YYYY)* / /
Child No. 3:	Name	*First*	*Middle*	*Last*	Date of Birth *(MM/DD/YYYY)* / /

4. REPLACEMENT

If this insurance is issued, will it replace any other accident coverage currently in force? ..... ☐ Yes ☒ No
If Yes, provide name of Insurance Company below and complete the Replacement Notice.

Insurance Company

Insurance Company

5. PREMIUM PAYMENT INFORMATION — Please indicate preference for payment type and billing frequency below.

Type

☐ Direct Billing ☐ Automatic Bank Withdrawal
☐ List Billing *(employer)* ☒ Automatic Credit Card

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☒ Monthly *(not available with Direct Billing)*

Payor Name *First* Vanessa *Middle* C *Last* Taylor

Billing Address *Street Address* 342 South Broadway Street Apt D33 *City* Greenville *State* MS *ZIP+4* 38701

6. PRODUCT INFORMATION — Policy benefits and riders may vary by state

Coverage Type: ☒ 24-Hour Accident Insurance ☐ Off-the-Job Accident Insurance

Coverage Period: ☒ Guaranteed Renewable to Age 80

Insured Options: ☒ Primary Insured Person Only ☐ Primary Insured/Spouse ☐ Primary Insured/Child(ren) ☐ Family

Benefit Packages — Choose a package

☐ Base ☒ Advantage ☐ Complete ☐ Other

Optional Riders

☒ Accidental Death Rider

☐ Accident-Only Disability Income Rider Monthly Benefit Amount $____ *(complete Employment Information section below)*

☒ Preventive Care Rider

7. EMPLOYMENT INFORMATION — Complete if applying for the Accident-Only Disability Income Rider

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ..... ☐ Yes ☐ No

Gross Monthly Income $

8. BENEFICIARIES — Complete if applying for the Accidental Death Rider

Primary Beneficiary

	First	Middle	Last	Relationship	Date of Birth	Share %
Name	[redacted]				/ /	100
Name					/ /	

Contingent Beneficiary

	First	Middle	Last	Relationship	Date of Birth	Share %
Name					/ /	
Name					/ /	

9. AGREEMENT

I *(We)* agree that:

1. All answers in this application are complete and true to the best of my *(our)* knowledge and belief and will be relied upon to determine insurability.
2. The first premium is equal to the full premium for the premium payment mode selected. If the first premium is paid on the date this application is signed, the insurance applied for becomes effective on that date subject to: a. the Company's underwriting requirements, b. the terms of the attached conditional receipt, and c. the terms of the policy applied for.
3. If the first premium is not paid on the date of this application, no insurance will be in effect unless: a. such policy is issued, delivered to and accepted by me *(us)*, and the entire first premium is paid during the Proposed Insured's lifetime, and b. at the time of such delivery, acceptance or payment, whichever is later, all information furnished in this application remains true and complete to the best of my *(our)* knowledge.
4. If the Policyowner is someone other than the Insured, in the event of the Policyowner's death (and no Contingent Owner(s) living), the Insured will become the Policyowner.

Substitute Form W-9 information (Request for Taxpayer Identification Number and Certification): I, the Owner, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signed in MS on 05 / 28 / 2024

State *Date (MM/DD/YYYY)*

DocuSigned by: [redacted]

Signature of Proposed Insured *Signature of Owner (if other than Proposed Insured)*