GCU

A Fraternal Benefit Society
5400 Tuscarawas, Beaver, Pennsylvania 15009-9513
Telephone: 800-722-4428

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

(Please print; use dark ink)

APPLICATION PART 1

1. Is the Proposed Insured a member of the Union? ☐ Yes ☐ No If no, apply for membership.
   Lodge No.: _____ Located at: _____

2. **PROPOSED INSURED**: _____
   First Middle Last
   Address: _____
   P.O. Box/Street City, State or Country, Zip
   Date of Birth: _____ Place of Birth: _____ Marital Status: _____ Gender: _____
   Soc. Sec. #: _____ Primary Telephone #: _____
   Occupation: _____ E-mail: _____
   Driver's License #: _____ Annual Income: $ _____

3. **LIFE PLAN**: _____ Coverage Amount: _____
   Riders (show amount when applicable): _____
   If spousal or child coverage rider is applied for, please complete the following:
   Name: _____ Relationship to Proposed Insured: _____ Date of Birth: _____
   Name: _____ Relationship to Proposed Insured: _____ Date of Birth: _____
   Name: _____ Relationship to Proposed Insured: _____ Date of Birth: _____
   Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual Payment with this application: $_____
   Automatic Premium Loan, if available? ☐ Yes ☐ No

4. **DIVIDEND OPTION** (if dividends are declared): ☐ Purchase paid-up insurance, if available ☐ Paid in cash
   ☐ Applied to next payment due ☐ Left on deposit, at interest, with the Union

5. **OWNER** (if other than Proposed Insured):
   _____ SSN: _____
   Name Relationship

6. **BENEFICIARY**:
   Primary 1: _____ SSN: _____
   Relationship to Proposed Insured: _____ Share: _____ %
   Primary 2: _____ SSN: _____
   Relationship to Proposed Insured: _____ Share: _____ %
   Primary 3: _____ SSN: _____
   Relationship to Proposed Insured: _____ Share: _____ %

   Contingent 1: _____ Relationship to Proposed Insured: _____ Share: _____ %
   Contingent 2: _____ Relationship to Proposed Insured: _____ Share: _____ %
   Contingent 3: _____ Relationship to Proposed Insured: _____ Share: _____ %

7. **DISCLOSURE OF EXISTING LIFE INSURANCE**:
   Does the Proposed Insured have any pending life insurance applications? ☐ Yes ☐ No
   Does the Proposed Insured currently have any life insurance or annuity contracts in force? ☐ Yes ☐ No
   Is the insurance applied for intended to replace any insurance policy or annuity now in force? ☐ Yes ☐ No
   If yes, furnish insurance company's name and address and the policy number to be replaced, if applicable.

Proposed Insured's Name: _____

Please provide details to "Yes" answers in Remarks section.	**Yes**	**No**
8. Has the Proposed Insured used any form of tobacco within the past 24 months?	☐	☐
9. Has any person proposed for coverage within the past 5 years:		
a) been convicted of driving while impaired (alcohol, drugs, other), had drivers' license revoked or suspended, or, within the last 24 months, plead guilty to or been convicted of 3 or more moving violations?	☐	☐
b) had an application for insurance declined, rated, or postponed?	☐	☐
c) flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐
d) engaged in parachuting, scuba diving, racing or other hazardous sports or intend to do so?	☐	☐
e) used or is now currently using marijuana, narcotics, intravenous drugs, cocaine, barbiturates, hallucinogens, or been treated for drug or alcohol abuse or been advised by a doctor to limit the use of alcohol or any medication, prescribed by a physician or not?	☐	☐
f) used any alcoholic beverage?	☐	☐
If yes, provide the following: Type: _____ Frequency: _____ Amount: _____		
g) been on parole or probation or been convicted of a felony or misdemeanor?	☐	☐
10. Within the next 2 years, does any person proposed for coverage plan to travel or reside outside the U.S. or Canada?	☐	☐
11. Is the Proposed Insured a U.S. citizen?	☐	☐
12. Has any person proposed for coverage ever had, or been diagnosed as having or received treatment or medical advice from a member of medical profession for:		
a) abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease of the heart, blood vessels or of the cerebrovascular system?	☐	☐
b) cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, malignant melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician?	☐	☐
c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?	☐	☐
d) any ear, nose, throat, lung disorder, or any respiratory disorder, including sleep apnea?	☐	☐
e) any disorder of the stomach, intestines, rectum, liver, pancreas, kidney or bladder?	☐	☐
f) lupus, connective tissue disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐
g) epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's disease, motor neuron disease or any other disease or disorder of the nervous system?	☐	☐
h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐
i) any disease, disorder, or abnormal screening or diagnostic tests related to the breast or reproductive organs?	☐	☐
13. Has any person proposed for coverage ever:		
a) been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
b) had an immune deficiency disorder or disease of the lymphatic system or immune mechanism except those related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐
14. Other than as stated above, within the past 5 years, has any person proposed for coverage:		
a) consulted, received treatment or advice from, or been prescribed medication by any other member of the medical profession?	☐	☐
b) had any abnormal diagnostic or screening tests or within the past 2 years been advised by a member of the medical profession to have any diagnostic test, hospitalization, surgical procedure or treatment that has not been done?	☐	☐
15. Have any of the Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke or any other hereditary disease? (If yes, indicate family member, age at onset of illness, and, if applicable, age at death in Remarks section.)	☐	☐

16. Please indicate the Proposed Insured's:

a) Current Height _____ Current Weight _____ Change in past year of 25 pounds or more? ☐ ☐

Cause of weight change _____

b) Name and address of usual physician _____

Date and reason of last visit _____

Treatment given or medication prescribed _____

If none, please write "none" here _____

17. **REMARKS** (explain yes answers to questions 8-16):

Question #	Person	Illness/Condition	Date & Duration	Treatment & Results	Doctors & Hospitals

AGREEMENT-AUTHORIZATION-ACKNOWLEDGEMENT – GCU

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of GCU.

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter:

AGREE to the following:

a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.
b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.
c) No agent has authority to waive any answer or otherwise modify this application or to bind GCU, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.
d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. (“MIB”), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization. It is understood that GCU underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. 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 its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and
b) MIB Pre-Notice.

FRAUD WARNING NOTICE

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.

GCU IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

Date

Printed name of Proposed Insured

Signature of Proposed Insured (or parent if Proposed Insured is under age 18)

Printed name of Spouse (if proposed for rider coverage)

Signature of Spouse (if proposed for rider coverage)

Printed name of additional Proposed Insured

Parent or Guardian (Juvenile Proposed Insured); or Member Applicant

Owner (if other than Proposed Insured)

Proposed Insured's Name: _____

AGENT'S REPORT

		Yes	No
1.	**Agent Checklist (provide details in Additional Remarks section below):**		
a)	Did you give the applicant a copy of the Privacy Notice and other disclosure information?	☐	☐
b)	Are you related to the Proposed Insured?	☐	☐
c)	Was this application taken in person?	☐	☐
d)	Do you know anything not disclosed which might affect the underwriting of this risk?	☐	☐
e)	Is there another application currently pending or being submitted to any other life insurance company?	☐	☐
f)	Has the Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?	☐	☐
g)	Is replacement of existing insurance involved in this application? (If yes, submit appropriate replacement forms.)	☐	☐

2. **If the Proposed Insured is age 0-16, please answer the questions below:**

a) Number of siblings _____ Do they all have the same amount of insurance as the Proposed Insured? ☐ ☐

b) If less than 1 year of age, what was the birth weight? _____ lb. _____ oz.

c) Did you see the child? ☐ ☐

d) Amount of life insurance in force and/or requested on:

Father $ _____

Mother $ _____

3. **Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.)**

a) Is this insurance part of a split dollar agreement? ☐ ☐

b) This business operates as a:

☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

c) What is the value of the business? $ _____

d) What percentage does the Proposed Insured own or control? _____ %

e) Are other key individuals applying? ☐ ☐

If yes, indicate name of each person. If no, for what reason? (use space below for details)

_____

_____

_____

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date _____ Agency _____ Code _____

Agent's Signature _____ Code _____

Agent's Signature _____ Code _____

CONDITIONAL RECEIPT

GCU

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met:

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt cannot exceed $100,000. This includes any previously pending insurance.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (A) one or more of the receipt's conditions have not been met exactly; (b) any proposed insured dies by suicide

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

GCU

LIFE PLAN_____ **Amount $**_____

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

By_____ _____ 20_____
Agent Date

NOTICE OF INFORMATION PRACTICES
(including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

This Notice must be given to Proposed Insured

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc, ("MIB")

Information regarding your insurability will be treated as confidential. GCU, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a non-for profit membership organization of life 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 it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. 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. The address of MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

GCU, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

GCU
5400 Tuscarawas Rd, Beaver PA, 15009
P 1.800.722.4428 F 724-495-3421 E info@GCUusa.com

Authorization
For Blood Testing and Disclosure of Results

I do hereby authorize blood to be drawn from me for laboratory tests. I understand that:

1. The tests performed will be those required by the Insurer to determine my eligibility for the insurance I have applied for;

2. I have the right to refuse to have blood drawn and that, in such event, the Insurer will decline to accept my application; and

3. The tests preformed shall include, but are not limited to, tests for:

    a. Cholesterol and related blood lipids; glucose; liver or kidney disorder; or the presence of medication, drugs, nicotine or metabolites; and
    b. Immune disorders; or T-Helper to T-Suppressor ratio with total T-cell count.

I further authorize:

1. The laboratory to disclose the test results to the Insurer;
2. The Insurer to disclosed the test results, including any abnormal results, to its reinsurer, provided such reinsurer is involved in the determination of my eligibility for insurance; and
3. The Insurer to make a brief, coded report to the Medical Information Bureau (MIB) in the manner described in the MIB Notice I received as a part of my application process.

I understand that the test results will be confidential. No one will have access the test results except: as I have authorized; as I may later authorize; or, as may be required by law.

Name of Proposed Insured (Please Print): _____

Address: _____

_____

Signature of Proposed Insured:_____

Witness:_____ _____
(Signature) (Printed Name)

Date: _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

GCU
5400 Tuscarawas Rd, Beaver PA, 15009
P 1.800.722.4428 F 724.495.3421 E info@GCUusa.com

Authorization for Electronic Payment (Debit) from Checking Account

(For transferring funds from your Financial Institution to your GCU account or certificate)

☐ New Request ☐ Change to Existing ☐ Cancel Existing

First Name: _____ Certificate Number(s): _____

Last Name: _____ _____

Address: _____ Last 4 Digits of SSN: _____

_____ Phone Number: (_____) _____

(Is this a new address? ❑ Yes ❑ No) Cell Phone: (_____) _____

Email Address: _____ Date of Birth:_____/_____/ _____

Financial Institution's Name: _____

Financial Institution's Phone: _____

Please complete the following information:

Authorized Amount: $_____.

Authorized month_____ and day _____ to apply electronic payment. (*Day must be between 1st - 28th*).

Desired Frequency of Electronic Payment:

☐ Monthly ☑ Quarterly ☐ Semi-Annually ☐ Annually

FOR ELECTRONIC PAYMENT

A Voided Check is Required.

PLEASE ATTACH HERE WITH TAPE.

I hereby authorize GCU to initiate electronic payment entries and to initiate, if necessary electronic deposits and adjustments for any entry in error to my (our) account indicated below and the financial institution named above, hereinafter called DEPOSITORY, to credit and/or debit the same to such account. This authority is to remain in full force and effect until GCU has received written notification from me (or either of us) of its termination in such time and in such manner as to afford GCU and DEPOSITORY a reasonable opportunity to act on it.

Owner's Signature Required_____ ***Date***_____

5400 Tuscarawas Road, Beaver, PA 15009-9513
Email: life.newbusiness@gcuusa.com Fax: 724-495-3421

Name of Proposed Insured	Insured Date of Birth

AGREEMENT-AUTHORIZATION-ACKNOWLEDGEMENT – GCU

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of GCU.

I, the Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereunder:
AGREE to the following:

a) All statements and answers in the application are complete and true to the best of my knowledge and belief.
b) No insurance will take effect unless the first full premium is paid and a policy is delivered and while my health continues, without material change, to be as represented in the application.
c) No agent has the authority to waive any answer or otherwise modify the application or to bind GCU, hereinafter called "Company", in any way by making any promised ore representation which is not set out in writing in the application.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization may include information about diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree a photographic copy will be as valid as the original and that it will be valid for the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization. It is understood that the Company's underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. 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 its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. This authorization will be valid for either: (a) 24 months; or (b) the maximum period of time permitted by applicable law in the state where the policy is delivered or issued for delivery. Such period of time will be measured from the date the authorization is signed. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and
b) MIB Pre-Notice.

_____ _____

Printed Full Legal Name of Individual Whose Information is to Be Disclosed

Date

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative or Parent/Guardian of minor