BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105146, Atlanta, Georgia 30348-5146 (404) 266-5600

Agent/Broker Name	Agent Number

APPLICATION FOR LIFE INSURANCE

(PLEASE PRINT)

PROPOSED INSURED(S) (First Name, Middle Initial, Last Name)	Relationship To Insured	Social Security Number	Sex	Place (State) of Birth	Age	Born Month	Born Day	Born Year	Height & Weight Feet	Inches	Lbs.
	Primary Insured										
	Spouse										

Residence Address (Street or Route & Box No.)	City	County	State	Zip Code
				–

Telephone Number ( ) | Best Time To Call __________ ❒ AM ❒ PM | E-Mail Address | Mail policy to: ❒ Insured ❒ Agent

SELECT THE COVERAGE YOU WANT BY CHECKING THE APPROPRIATE BOXES BELOW

REQUESTED FACE AMOUNT:

Level Whole Life: $_______________

Minimum Face Amount = $5,000
Maximum Face Amount = $49,999

Single Premium: $_______________

Maximum Net Amount Risk= $49,999

OPTIONAL RIDERS:

❑ Children's Insurance Rider ___ units
❑ Family Insurance Rider ___ units
❑ Accidental Death Rider
❑ Waiver of Premium Rider

Automatic Premium Loan: ❑ Yes ❑ No

PREMIUM MODE:

❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly Bank Draft*
❑ Monthly Credit Card*

*Requested Draft Date ___________

MODAL PREMIUM:

Total Amount Paid with Application .... $ ______________

❒ Check/money order included. ❒ Draft initial premium*.
❒ Charge credit card for initial premium. *Initial Draft Date ____________

REQUESTED EFFECTIVE DATE: ___________________________

BILLING TYPE: ❑ Individual ❑ Family*

*Complete Family Billing Form B 0129 FB/LB

TOBACCO USE: ❑ Yes ❑ No

If you have used any tobacco product in the last three years, answer "Yes"

1. Is each Proposed Insured a legal citizen of the United States or its possessions? .... ❑ Yes ❑ No

If "No," Name	Permanent Resident	If Permanent Resident: INS #	Category	Resident Since	Card Expires
____________	❑ Yes ❑ No	____________	____________	____________	____________
____________	❑ Yes ❑ No	____________	____________	____________	____________
____________	❑ Yes ❑ No	____________	____________	____________	____________

If not a Permanent Resident, coverage is not available for that person.

2. (a) Does any Proposed Insured currently have any existing life insurance policies or annuities?................................ ❑ Yes ❑ No
   (b) Will any life insurance or annuities be replaced with this policy of level whole life insurance? .... ❑ Yes ❑ No

BENEFICIARY DESIGNATIONS

3A. Primary Insured

Name of Primary Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.

Name of Contingent Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.

3B. Spouse

Name of Primary Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.

Name of Contingent Beneficiary(ies)	Relationship	Social Security No. *(If known)*	Address	Telephone No.

3C. Dependent Children *(Beneficiary will be Primary Insured unless otherwise noted)*

Dependent Name	Name of Primary Benefiary	Relationship	Social Security No. *(If known)*	Address	Telephone No.

(Application continued next page)

4. Name of Owner (If other than Primary Insured)	Relationship	Social Security No. (If known)	Address	Telephone No.
Name of Payor (If other than Primary Insured)	Relationship	Social Security No. (If known)	Address	Telephone No.

5. In the last 7 years, has any Proposed Insured had or been medically diagnosed with or treated for:
   (a) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? ❑ Yes ❑ No
   (b) any lipidosis, including Gaucher's, Niemann-Pick, Tay-Sach's or Wolman's? ❑ Yes ❑ No
   If the answer to any part of Question 5 is "Yes," coverage is not available for that Proposed Insured(s)
6. In the past 5 years, has any Proposed Insured had or been medically diagnosed with or treated for:
   (a) heart disease or disorder of any kind, including but not limited to heart attack, congestive heart failure (CHF), heart surgery, angina or pacemaker implant? ❑ Yes ❑ No
   (b) circulatory disease or disorder of any kind, including but not limited to stroke, aneurysm or blood vessel disorder? ❑ Yes ❑ No
   (c) respiratory disease or disorder of any kind, including but not limited to emphysema, chronic obstructive pulmonary disease (COPD) or any chronic lung disorder? ❑ Yes ❑ No
   (d) kidney disease or disorder, or liver disease or disorder of any kind, including but not limited to kidney failure, kidney dialysis, kidney transplant, cirrhosis of the liver, or hepatitis (excluding Type A)? ❑ Yes ❑ No
   (e) brain disease or disorder of any kind, including but not limited to brain tumor, Down's syndrome, cerebral palsy, mental retardation, mental illness or disorder or seizure disorder? ❑ Yes ❑ No
   (f) internal cancer, leukemia, malignant melanoma or Hodgkin's disease? ❑ Yes ❑ No
   (g) degenerative disease or disorder of the muscles or nerves of any kind, including but not limited to Lou Gehrig's disease (ALS), multiple sclerosis, muscular dystrophy, Huntington's Chorea, Myasthenia Gravis or Parkinson's disease? ❑ Yes ❑ No
   (h) diabetes? ❑ Yes ❑ No
   (i) alcoholism, drug or substance addiction or abuse? ❑ Yes ❑ No
7. In the past 5 years, has any Proposed Insured been medically treated by a physician? ❑ Yes ❑ No
8. In the past 2 years, has any Proposed Insured been advised by a physician to have any medical or surgical treatment or tests and not done so? ❑ Yes ❑ No
9. Provide details to any "Yes" answers to questions 5 through 9. Include Proposed Insured's name, question number, date, diagnosis, physician's name and address: ______________________________

____

____

10. Physician Information:

Proposed Insured Name	Primary Physician Name	Address	Telephone Number	Date and Reason Last Consulted

11. Has any Proposed Insured ever had any life or health insurance rated or modified? ❑ Yes ❑ No

    If "Yes," provide: Proposed Insured Name ______________________________
    Name of Company: ______________________________ Date: ____________
    Reason: ______________________________
12. In the last 3 years, has any Proposed Insured had:
    (a) 3 or more moving violations? ❑ Yes ❑ No
    (b) been charged with driving while intoxicated or under the influence? ❑ Yes ❑ No
    (c) had your driver's license suspended or revoked? ❑ Yes ❑ No

    If "Yes," provide: Proposed Insured Name ______________________________
    Driver's License #: ______________________________ State of Issue: ______________
13. Does any Proposed Insured:
    A. fly an airplane, ultralight or helicopter? (If "Yes," complete aviation form.) ❑ Yes ❑ No
    B. intend to participate in the future or have you participated in the last 2 years in parachuting, aerobatics, underwater diving, hang-gliding, rodeoing, mountain climbing, professional sports or organized racing of any kind? (If "Yes," complete avocation questionnaire.) ❑ Yes ❑ No

 (Application continued on next page)

(Application continued)

14. I, the undersigned Proposed Primary Insured, hereby apply to Bankers Fidelity Life Insurance Company® for a policy to be issued solely and entirely in reliance on my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, true. **I agree the policy shall not be effective unless it has actually been issued, received by the Owner and the first premium paid and honored upon first presentation, all during my lifetime and before any change in my health as stated herein.**

The undersigned Proposed Insured and agent state that the Proposed Insured has read or had read to him/her the completed application and that the Proposed Insured realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the policy, subject to the "Incontestability" provision of the policy.

CAUTION: If the answers on this application are materially incorrect or untrue, Bankers Fidelity Life Insurance Company® may have the right to deny benefits or contest the policy, subject to the "Incontestability" provision of the Policy.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at ________________________ (City and State), on ____________ (Month, Day, Year)

X ________________________ Proposed Primary Insured's signature. Please read item 14 before signing

X ________________________ Spouse's signature (Proposed Insured if family insurance applied for)

X ________________________ Owner's signature (If Other than Applicant or Proposed Insured)

X ________________________ (Applicant's signature if other than Proposed Insured)

X ________________________ Signature of Parent if Proposed Insured is less than 15 years old and Parent is NOT the Owner.

X ________________________ Agent's signature Agent's number

Complete form B 0148 HIPAA.

WRITING AGENT COMPLETE

Is any of this insurance being purchased to replace or change any existing insurance or annuities? .... ❑ Yes ❑ No

If "YES" complete Replacement Notice(s) as required.

I, the undersigned agent, certify that: (1) I have personally interviewed the Proposed Insured; and (2) I have accurately recorded the information supplied by the Proposed Insured.

Is the Proposed Insured related to you? ❑ Yes ❑ No If "Yes," explain relationship: ❑ Self ❑ ________________________
If "YES," the co-signature of an independent third party is required.

I certify that I have independently verified the Proposed Insureds identity as required by the USA Patriot Act (PL107-56) by viewing or through a U.S. Federal or state government-issued photo I.D.:
❑ Drivers License ❑ Passport ❑ Government-issued identification card ❑ Other ________________________

Dated at ________________________ City and State, on ____________ Month, Day, Year

X ________________________ Agent's signature Agent's number

X ________________________ Co-signature *(if required)*

B 2-1086 AP2006 MO (7-12)

AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO BANKERS FIDELITY LIFE INSURANCE COMPANY®, ATLANTA, GA

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Bankers Fidelity Life Insurance Company®, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Bankers Fidelity Life Insurance Company® has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

SELECT A OR B

A. ❑ CHECKING AUTHORIZATION ❑ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:		Type of Financial Institution: ❑ Bank ❑ Credit Union
Routing/ABA Number:	Account Number:	**Attach a void check if the account number is different than the account number on the initial premium. If the authorization is for a Savings Account, attach a deposit slip.**
Signature of Account Holder	Date	

B. ❑ CREDIT CARD AUTHORIZATION

Type of Card: ❑ Mastercard ❑ Visa ❑ Discover	Account Number:
Name of Card Holder as it appears on account	Expiration Date ____ / ____ Month Year
Signature of Card Holder	Date

B 0129 MBD/CC (7-12)