UnionCentral

Application for Policy Change

The undersigned hereby requests and directs The Union Central Life Insurance Company to change policy number:_____
on the life of:_____

1. LIFE INSURANCE:

A. Change Benefit Amount: ☐ Increase Amount ☐ Decrease Amount
To: $_____ (Base) To: $_____ * (Rider)
To: $_____ * (Rider)

*Unless provided otherwise in the policy, an increase/decrease in the base will result in a proportionate increase/decrease in the Disability Benefit Amount, if any. No increase will be made to the Accidental Death Benefit unless specifically indicated above. However, if the base is decreased, the Accidental Death Benefit will decrease for a like amount.

B. ☐ ADD ☐ CANCEL ☐ INCREASE to: $_____
☐ Scheduled Increase Option ☐ Accidental Death: _____
☐ Other Insured ☐ Smoker ☐ Nonsmoker ☐ Guaranteed Insurability: _____
☐ Children's Insurance ☐ _____
☐ Cost of Living Rider ☐ _____

C. ☐ Change Death Benefit Option to: ☐ OPTION A ☐ OPTION B (Evidence of insurability required to change to Option B)

D. ☐ Change Planned Periodic Premium to: $_____ per Premium Interval
(I understand any increase is subject to the expense charges shown in the Policy Schedule.)

E. ☐ Election of Nonforfeiture Option. Endorse as: ☐ Reduced Paid-Up ☐ Extended Term

F. ☐ Change to Fully Paid-Up Policy.

2. DISABILITY INCOME:

A. ☐ Change Occupation Class to:_____

B. ☐ Change Waiting Period to: _____ days. Change benefit period to:_____ years.

C. ☐ ADD ☐ CANCEL ☐ INCREASE ☐ DECREASE TO: $_____
☐ Partial Disability ☐ Guaranteed Insurability ☐ Social Insurance Rider
☐ Cost of Living/Inflation ☐ Residual Disability ☐ Automatic Increase
☐ Automatic Increase Rider Renewal ☐ Monthly Benefit ☐ Hospital Income ☐ Other _____

D. ☐ Reconsider Rating and/or Exclusion Rider

3. GENERAL:

A. ☐ Change Premium Mode to: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Check-O-Matic (Attach voided personal check) ☐ List Bill

B. ☐ Change Smoker/Tobacco Status to: ☐ Nonsmoker ☐ Non-Tobacco

C. ☐ Additional Particulars:_____

For any change, it is agreed that: (a) evidence of insurability will be furnished if required; and (b) any net value of a policy being changed to a new policy will be applied towards the new policy.

I hereby declare that: (a) no bankruptcy proceedings are now pending against the owner; and (b) no assignment of the policy numbered above has been made except to (if no exception, so state). _____

I have reviewed and understand the applicable fraud warning on the next page.

IMPORTANT: Please note, if the policyowner is a resident of a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, and WI), the policyowner's spouse is required by that state to sign this form as "Other Required Signature". The form will be returned if incomplete. If the policyowner has never been married, then please state "Not Married" on the "Other Required Signature" line. If the policyowner is divorced or the spouse is deceased, we will need verification of this for our records for future requests, ie, certified copy of death certificate, certified copy of divorce decree.

Dated at:_____ Month: _____ Day: _____ Year:_____
City State

Insured Signature: _____ Owner Signature:_____

Other Required Signature: _____ Creditor Assignee:_____

If signing for a corporation, show corporate title.

Name of Corporation:_____

Officer:_____ Title: _____

Acknowledged: THE UNION CENTRAL LIFE INSURANCE COMPANY

By: _____ Date: _____

(From Agency No.: _____) NOTE: Mail completed matter to: ☐ Owner ☐ Agency No.: _____

UnionCentral

Application for Insurance

Fraud Notice

Unless specific state language is noted below, the following general fraud notice applies. In New York, the fraud notice only applies to Disability Income and Overhead Expense coverage.

FRAUD NOTICE
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer; submits an application or files a claim containing a false or deceptive statement; is guilty of insurance fraud.

CA RESIDENTS
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud if convicted of such charges in a court of law.

CO RESIDENTS
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC AND PA RESIDENTS
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 subjects such person to criminal and civil penalties. The general fraud notice stated above does not apply to DC or Pennsylvania residents.

FL RESIDENTS
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GA, KS, MD, NE, OR, VT AND WY RESIDENTS
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

LA RESIDENTS
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME & TN RESIDENTS
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NJ RESIDENTS
Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

NM RESIDENTS
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY RESIDENTS
This fraud warning is applicable only to disability income products and not to life insurance products. 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

TX RESIDENTS
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

VA RESIDENTS
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

WA RESIDENTS
Any person who knowingly presents fake or fraudulent claim for payment of a loss or knowingly makes a fake statement in an application for insurance may be guilty of a criminal offense under state law.

UnionCentral

Authorization to Obtain and Disclose Information

(This authorization complies with the HIPAA Privacy Rule.)

I authorize any health care providers, hospitals, insurers, the Medical Information Bureau, Inc., consumer reporting agency, government agency, financial institution, or employer; having data or facts about the proposed insured's or claimant's physical or mental condition, medical care, advice, treatment, the use of drugs, alcohol, or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to The Union Central Life Insurance Company ("the Company"), its reinsurers, or any other agent or agency acting on the Company's behalf.

Data or facts obtained will be released only to: (1) reinsurers; (2) the MIB; (3) persons performing business duties as delegated or contracted for by the Company related to the proposed insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government authorities when necessary to prevent or prosecute fraud or other illegal acts; (6) and to any person or entity having an authorization expressly permitting the disclosure. The personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

The above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

I agree that this authorization is valid for 24 months years from the date shown below. I also agree that a copy is as valid as the original. I or my authorized representative am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Company's ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

I acknowledge receipt of Notice of Insurance Information Practices.

Dated at: _____
City State Month Day Year

_____
Print or Type Name of Proposed Insured

X _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

_____
Print or Type Name of Personal Representative of Proposed Insured

X _____
Signature of Personal Representative of Proposed Insured

_____
Description of Authority of Personal Representative
(Parent, Legal Guardian, Attorney-in-Fact)
(Attach documentation in support of your authority.)