UnionCentral

Application for Insurance

Instructions and Checklist

Founded in 1867 . . . A Mutual Company

1. The Notice of Insurance Information Practices must be given to the client prior to completion of the application.
2. The proposed insured, spouse, and applicant, if any, must sign the form where indicated.
3. We will not accept applications on minors younger than fifteen (15) days old. A parent or guardian must give consent to any applicant under age 18.
4. ALL questions must be answered. Changes to answers must be initialed and dated by the proposed insured and the applicant, if the applicant is not the proposed insured. Do not use white out to change any answers, or fill in any blank information after the application has been signed.
5. Taxpayer Identification Number and Certification form must be completed and returned to the Home Office.
6. If a life insurance or annuity contract is being replaced, you must follow appropriate replacement procedures.

PLEASE HELP US PROCESS YOUR CASE AS QUICKLY AS POSSIBLE BY COMPLETING THIS CHECKLIST

TELL US THE TYPE OF PRODUCT BEING SUBMITTED AND WHICH FORMS ARE INCLUDED

☐ **TRADITIONAL & UNIVERSAL LIFE** ☐ **VARIABLE UNIVERSAL LIFE** ☐ **DISABILITY INCOME**

				Included?
Application Kit Forms automatically printed with the Main Application Form UC 2550	Always Submit	UC 2550 NI	Notice of Insurance Practices	☐ Yes ☐ No
		UC 2550 PI	Personal Information	☐ Yes ☐ No
		UC 2550 LQ	Lifestyle Questionnaire	☐ Yes ☐ No
		UC 2550 HQ	Health Questionnaire *(for each proposed insured)**	☐ Yes ☐ No
		UC 2550 FN	Fraud Notice	☐ Yes ☐ No
		UC 2550 AU	Authorization	☐ Yes ☐ No
		UC 2550 AG	Agreement	☐ Yes ☐ No
		UC 2550 AS	Agent's Statement	☐ Yes ☐ No
		UC 2550 CR	Conditional Receipt** *(see instructions below)*	☐ Yes ☐ No
		UC 2550 LIFE	Traditional Life and Universal Life Policy Details	☐ Yes ☐ No
		UC 2550 FI	Life Financial Information	
		or		
		UC 2550 VUL	Variable Universal Life Policy Details	☐ Yes ☐ No
		UC 2550 FI	Life Financial Information	
		UC 2550 SI	Suitability Information	
		or		
		UC 2550 DI	Disability Income Policy Details	☐ Yes ☐ No
		HIV Consent Forms	*(State Variations Exist)*	☐ Yes ☐ No
Available on Demand	Submit as Required Additional Forms that may be Required	UC 2178	Check-O-Matic Forms	☐ Yes ☐ No
		State Replacement forms *(State variations exist)*		☐ Yes ☐ No
		UC 5005	Carillon Switch Form *(Required for Variable Business)*	☐ Yes ☐ No
		UC 1117	1035(a) Exchange of Life Insurance/Annuity Policy	☐ Yes ☐ No
		UC 1441	Internal Replacement Form *(Traditional & Universal Life)*	☐ Yes ☐ No
		UC 626	Term to Term Cancellation form	☐ Yes ☐ No

*If the coverage requested is within the Company's nonmedical limits, no other application forms are required. If the coverage requested exceeds our published nonmedical limits, a medical or paramedical examination should be obtained. If you learn of any adverse information after the application has been submitted and before the policy is issued or delivered, you are required to report it immediately.

**Conditional Receipt is given to the premium payor whenever full initial premium is collected. Do not accept premium if the amount of life insurance requested exceeds a death benefit of $1,000,000, or $8,000 per month of Disability Income or Disability Overhead Expense. Also, premium should not be accepted if the proposed insured is age 75 or older, or has been treated for heart disease, diabetes, stroke, or cancer within the past 12 months, or has been admitted to a medical facility within the past 90 days. Premium payments must be made by personal or business check only. No cash, money orders, traveler's checks or bank checks are permitted.

UnionCentral

Application for Insurance

Notice of Insurance Information Practices

To issue an insurance policy we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. We may obtain information relating to any proposed insured's mental and physical health, general character and reputation, habits, finances, occupation, other insurance coverage, or participation in hazardous activities.

This information may be obtained from physicians, medical professionals, hospitals, clinics or other medical care institutions, or from the Medical Information Bureau, public records, consumer reporting agencies, financial sources, other insurance companies, agents, friends, neighbors and associates. We may obtain information through exchanges or correspondence, by telephone or by personal contact.

Information regarding your insurability or claims will be treated as confidential. The Union Central Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number (617) 426-3660. The Union Central Life Insurance Company or its reinsurers may also release information in its file 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.

Furthermore, as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, associates, or others with whom you are acquainted. This inquiry and any subsequent investigative consumer report update which may also be requested includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. You also have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

To reduce costs and offer insurance coverage at the lowest possible premium, the Company may also use a Personal History Interview. A specially trained interviewer may call to discuss information contained in your application or to ask questions related to the underwriting of your insurance. We will attempt to conduct this telephone interview at your convenience and at a number you designate.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. A description of the circumstances under which information about you might be disclosed without your authorization will be sent to you upon request.

You have a right of access to personal information we maintain in our files and to request correction, amendment, or deletion of any information you believe to be incorrect. You may request a description of established procedures which will allow access to and correction of such personal information.

If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact: Underwriting Department, The Union Central Life Insurance Company, P.O. Box 40888, Cincinnati, Ohio 45240-0888.

DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION.

UnionCentral

Application for Insurance

Personal Information

To the best of the applicant's knowledge and belief:

1. Proposed Insured (One):

a) Name: _____

b) Date of Birth: _____ c) Sex: ☐ Male ☐ Female

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

f) Driver's License No.: _____ State: _____

g) Home Address: _____

_____

City: _____ State: _____ Zip: _____

h) Years at this Address: _____

i) Tel. *(Home)*: _____

(Business): _____

Fax: _____

E-mail: _____

Best time to call: _____ at ☐ Business ☐ Home

In the event you are not available when our interviewer calls, may we speak with your spouse? ☐ Yes ☐ No

j) Residency Status: ☐ U.S. Resident ☐ Other: _____

k) Citizenship if other than U.S.: _____
(Complete Foreign National form UC 0918.)

l) Employer Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

m) Occupation: _____ Years: _____

n) Duties: _____

2. Proposed Insured (Two): *(Not applicable to DI.)*

a) Name: _____

b) Date of Birth: _____ c) Sex: ☐ Male ☐ Female

d) Place of Birth: _____

e) Social Security/Tax ID No.: _____

f) Driver's License No.: _____ State: _____

g) Home Address: _____

_____

City: _____ State: _____ Zip: _____

h) Years at this Address: _____

i) Tel. *(Home)*: _____

(Business): _____

Fax: _____

E-mail: _____

Best time to call: _____ at ☐ Business ☐ Home

In the event you are not available when our interviewer calls, may we speak with your spouse? ☐ Yes ☐ No

j) Residency Status: ☐ U.S. Resident ☐ Other: _____

k) Citizenship if other than U.S.: _____
(Complete Foreign National form UC 0918.)

l) Employer Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

m) Occupation: _____ Years: _____

n) Duties: _____

3. Proposed Insured (Child One or Other): *(Not applicable to DI.)*

a) Name: _____

b) Relationship: _____

c) Date of Birth: _____ d) Sex: ☐ Male ☐ Female

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

4. Proposed Insured (Child Two or Other): *(Not applicable to DI.)*

a) Name: _____

b) Relationship: _____

c) Date of Birth: _____ d) Sex: ☐ Male ☐ Female

e) Place of Birth: _____

f) Social Security No: _____

g) Ins. in Force/Company: _____

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Application for Insurance
Personal Information (continued)

5. Owner One: *(Complete only if Owner is other than Proposed Insured.)*

a) Name:_____

b) Relationship to Proposed Insured(s):_____

c) Date of Birth:_____

d) Social Security/Tax ID No.:_____

e) Driver's License No.:_____ State:_____

f) Address:_____

_____

City:_____ State:_____ Zip:_____

g) Tel. *(Home)*:_____

(Business):_____

Fax:_____

E-mail address:_____

h) Residency Status: ☐ U.S. Resident ☐ Other_____

i) Citizenship if other than U.S.:_____
(Complete Foreign National form UC 0918.)

6. Owner Two: *(Complete only if Owner is other than Proposed Insured.)*

a) Name:_____

b) Relationship to Proposed Insured(s):_____

c) Date of Birth:_____

d) Social Security/Tax ID No.:_____

e) Driver's License No.:_____ State:_____

f) Address:_____

_____

City:_____ State:_____ Zip:_____

g) Tel. *(Home)*:_____

(Business):_____

Fax:_____

E-mail address:_____

h) Residency Status: ☐ U.S. Resident ☐ Other_____

i) Citizenship if other than U.S.:_____
(Complete Foreign National form UC 0918.)

7. Ownership Information: *(Complete entity type and information.)*

a) ☐ Individual

b) ☐ Partnership

c) ☐ Corporation

Country of Incorporation:_____

d) ☐ Trust

Date of trust:_____

Trustee Name:_____

Residency Status: ☐ U.S. Resident ☐ Other:_____

Citizenship if other than U.S.:_____
(Complete Foreign National form UC 0918.)

e) Multiple Ownership: *(Indicate type of ownership.)*
☐ Joint with right of survivorship
☐ Tenants in Common *(shared ownership)*

f) Successor Owner: *(Recommended for Juvenile Insurance Policy. Not recommended for buy-sell or policies used by a business.)*

Name:_____

Social Security/Tax ID No.:_____

8. Beneficiary Information: *(Subject to change by Owner.)*

a) Primary Beneficiary:_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to Proposed Life Insured(s):_____

Social Security Number:_____

Date of Birth:_____

b) Contingent Beneficiary:_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to Proposed Life Insured(s):_____

Social Security Number:_____

Date of Birth:_____

UnionCentral

Disability Income

Policy Details

To the best of the applicant's knowledge and belief:

1. Individual Disability Insurance:

a) Contract Form to include: *(Definition Of Disability)*
- ☐ UC 4401(65) An "own occ" definition for the entire benefit period.
- ☐ UC 4401(65NW) An "own occ and not engaged in any" definition for the entire benefit period.
- ☐ UC 4401(60) An "own occ" definition for 60 months and then "any reasonable occ" thereafter.
- ☐ UC 4401(60NW) An "own occ and not engaged in any" definition for 60 months and then "any reasonable occ" thereafter.
- ☐ UC 4401(24) An "own occ" definition for 24 months then "any reasonable occ" thereafter. The definition of Disability cannot exceed the benefit period.

b) Base Monthly Benefit: $ _____

c) Optional Riders:
- ☐ Residual Disability Rider *(to age 65)*
- ☐ Residual Disability Rider *(24 Months)*
- ☐ Partial Disability Rider
- ☐ Inflation Rider
- ☐ Social Insurance Substitute Rider:
  - Amount: $ _____
  - Waiting Period *(Days)*: _____
- ☐ Activities Of Daily Living Rider:
  - Amount: $ _____
  - Waiting Period *(Days)*: _____
  - Benefit Period *(Years)*: _____
- ☐ Guaranteed Physical Insurability Rider
- ☐ Automatic Increase Rider
- ☐ Other: _____

d) Waiting Period *(Days)*:
☐ 30 ☐ 60 ☐ 90
☐ 180 ☐ 365

e) Benefit Period:
☐ 1 Year ☐ 5 Years
☐ 2 Years ☐ To Age 65

f) Do you understand and agree that under the terms of the Individual Disability Income policy applied for, no monthly benefit is payable during the waiting period of any disability?
☐ Yes ☐ No

2. Disability Overhead Expense:

a) Base Monthly Benefit: $ _____

b) Optional Riders:
- ☐ Future Increase Rider
- ☐ Salary Substitute Expense Rider

c) Waiting Period:
☐ 30 ☐ 60 ☐ 90

d) Benefit Period *(Months)*:
☐ 12 ☐ 18 ☐ 24

e) Do you understand and agree that under the terms of the Disability Overhead Expense policy applied for, no monthly benefit is payable during the waiting period of any disability?
☐ Yes ☐ No

3. Premium:

a) Premium Payor:
- ☐ Insured
- ☐ Employer
- ☐ Other _____

b) Send Premium Notices to:
- ☐ Residence
- ☐ Business
- ☐ Other *(Specify relationship and address.)* _____

c) Premium Frequency: _____
- ☐ Annual
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Step Rate
- ☐ Check-O-Matic *(Use form UC 2178.)*
- ☐ Salary Allotment/List Bill
  List bill number: _____
- ☐ Other: _____

d) Premium Discounts: ☐ Yes ☐ No
(If "yes," complete UC IH 4116-1 NJ)

e) Association Discount:
☐ Yes ☐ No (*If "Yes" give IPN.*)
Association IPN: _____

f) Has any premium been given in connection with this application?
☐ Yes ☐ No *(If "Yes" state amount paid for which conditional receipt has been given, the terms of which are hearby agreed to.)*
Amount: Individual Disability $ _____
Disability Overhead Expense: $ _____
Total: $ _____

4. Occupation / Employment:

a) Do you have any ownership in the business where you work?
☐ Yes ☐ No If yes, what percent do you own? _____

b) If yes, what type of business is it?
☐ C-Corp ☐ S-Corp
☐ LLP ☐ LLC
☐ Partnership ☐ Sole Proprietor
☐ Other: _____

c) If yes, how many other owners or partners are there? _____

d) How many total employees are there in the business where you work?
_____

e) How long have you been employed at the business where you work?
_____

f) How many hours per week do you work in your primary occupation?
_____

g) How long have you worked in your primary occupation?
_____

h) Do you have any other occupations not listed elsewhere on this application? ☐ Yes ☐ No

i) If yes, provide details: *(Include description of duties and hours worked per week.)* _____
_____

j) If this application is for Individual Disability Insurance, will your employer pay the premium for this coverage? ☐ Yes ☐ No

k) If yes, what percent will be paid by the employer? _____

l) If yes, will the premium paid by the employer be included in your taxable income? ☐ Yes ☐ No

m) Have you ever had a professional license suspended, revoked, or is such license under review, or have you been disbarred?
☐ Yes ☐ No

n) If yes, provide details: _____
_____
_____

UnionCentral

Disability Income

Occupation and Financial Details

To the best of the applicant's knowledge and belief:

5. Financial Information:

a) Annual Earned Income for Federal income tax purposes:
(Fill in each applicable section.)

	Current Tax Year *(Annualized)*	Last Tax Year	Two Tax Years Ago
Salary/ W-2 wages:	$	$	$
Sole Proprietor *(Schedule C)*:	$	$	$
Partnership *(Schedule E)*:	$	$	$
S-Corp *(Schedule E)*:	$	$	$
LLC or LLP *(Schedule E)*:	$	$	$
C-Corp *(Form 1120)*:	$	$	$

b) Annual Unearned Income for Federal income tax purposes:
(rental income, interest, dividends, etc.) $

c) Do you receive a pension or profit sharing contribution from the business where you work? ☐ Yes ☐ No

d) If yes, what is the annual contribution? $

e) Net Worth: *(If net worth exceeds $4,000,000, itemize below.)*
Cash, savings, stocks, bonds: $
Personal residence: $
Other real estate: $
Business interest: $
Personal Property: $
Other *(describe)*: $

f) Have you ever filed for personal or business bankruptcy?
☐ Yes ☐ No
(If yes, provide details, including dates, and whether/when discharged):

6. Existing Insurance *(Replacement)*:

a) Will any disability insurance with Union Central or any other insurance company be replaced, reduced or changed if the insurance now applied for is issued? ☐ Yes ☐ No
If yes, provide the following details:
Company:
Policy Number:
Amount to be replaced: $
Other changes:

7. Agents Replacement Statement:

a) To the best of your knowledge, does the policy applied for involve replacement, in whole or in part, of any existing life insurance, annuity, disability income or overhead expense insurance, or any other accident and sickness insurance?
☐ Yes ☐ No (If "Yes," give details.)
Company:
Policy No.:

8. Insurance Details:

a) Do you have any disability insurance in force, applications for disability insurance currently pending, or disability insurance for which you will become eligible in the next one year?
☐ Yes ☐ No

b) If yes, list coverage details in the following table.
(For type of coverage, indicate as group, individual disability, association, overhead expense, key person, buy-out, etc.)

	Policy 1	Policy 2
Company:		
Type of Coverage:		
Total Monthly Benefit:		
Issue Date:		
Paid to Date:		
Social Security Benefit:		
Automatic Increase Option:		
Future Increase Option:		
Employer Paid:		

9. If applying for Disability Overhead Expense Insurance, complete the following:

a) Not including you, what is the number of employees and partners in your profession in the business where you work?
Employees _____ Partners _____

b) For what percent of the total monthly overhead expenses are you responsible? %

c) List that portion of monthly overhead expenses for which you are responsible: *(Exclude payments or salaries paid to you, employees or partners in your profession.)*
Rent/Lease: $
Utilities: $
Telephone: $
Depreciation: $
Liability Insurance: $
Property Taxes: $
Salaries: $
Mortgage Interest: $
Payroll taxes: $
Employee Benefits: $
Other $

d) If you are reimbursed in any manner for any of the above expenses, provide complete details:

UnionCentral

Application for Insurance

Lifestyle Questionnaire

To the best of the applicant's knowledge and belief:

Lifestyle Questions: *(Please provide details for "Yes" answers.)*

Has any person proposed for coverage:

1. Used tobacco or nicotine products in any form within the last five years? *(This includes cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum.)* ☐ Yes ☐ No
2. Ever applied for insurance or reinstatement which has been: declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? ☐ Yes ☐ No
3. Ever received or claimed: indemnity, benefits, or a payment for any injury, sickness or impaired condition? ☐ Yes ☐ No
4. Ever made any flights as: a pilot, student pilot, or crew member of any aircraft in the past three years or intend doing so? *(If "Yes," complete Aviation Questionnaire UC 1217A.)* ☐ Yes ☐ No
5. Been convicted of a moving traffic violation or had a driver's license revoked or suspended within the past three years? ☐ Yes ☐ No
6. Been charged with or convicted of or currently awaiting trial on the violation of any criminal law? ☐ Yes ☐ No
7. In the next year, any intention of traveling outside the U.S. or Canada or residing outside of the U.S.? *(If "Yes"' complete Foreign Travel Questionnaire UC 287 AB.)* ☐ Yes ☐ No
8. Belong to or intend joining: any active or reserve military, naval, or aeronautic organization? *(If "Yes," complete Military Service Questionnaire UC 287 MS.)* ☐ Yes ☐ No
9. Engaged in or plan to engage in any form of the following: *(Selection requires completion of appropriate Form UC 287 C.)*

☐ Motorized Racing	☐ Scuba diving
☐ Parachuting/Skydiving	☐ Hang-gliding
☐ Ballooning	☐ Mountain climbing
☐ Rodeo	☐ Competitive skiing
☐ Snowmobiling	☐ Gliding
☐ Boat racing	☐ Other:_____

Proposed Insured One - Details for any "Yes" answers to Lifestyle Questions: *(Indicate question number and timeframe.)*

Proposed Insured Two - Details for any "Yes" answers to Lifestyle Questions: *(Indicate question number and timeframe.)*

UnionCentral

Application for Insurance
Health Questionnaire

To the best of the applicant's knowledge and belief:

Name of Proposed Insured: _____

Health Questions. Please complete Details for "Yes" answers.

1. a) Height _____ b) Weight _____
   c) Have you lost more than 10 lbs in the past 12 months? ☐ Yes ☐ No
2. Have you ever been medically treated for or had any known indication of:
   a) Disorder of eyes, ears, nose, or throat? ☐ Yes ☐ No
   b) Dizziness, vertigo, fainting, seizures, recurrent headache; speech defect, paralysis, or stroke? ☐ Yes ☐ No
   c) Shortness of breath, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? ☐ Yes ☐ No
   d) Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   e) Jaundice, intestinal bleeding; ulcer, hernia, colitis, hepatitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? ☐ Yes ☐ No
   f) Sugar, albumin, blood or pus in urine; sexually transmitted disease; stone or other disorder of kidney or bladder? ☐ Yes ☐ No
   g) Diabetes; thyroid, or other endocrine disorders? ☐ Yes ☐ No
   h) Disorder of breasts, reproductive organs, or prostate? ☐ Yes ☐ No
   i) Neuritis, arthritis, rheumatism, gout, or disorder of or injury to the bones, muscles, nerves, knees, wrists or other joints? ☐ Yes ☐ No
   j) Disorder of skin, lymph glands, cyst, tumor or cancer? ☐ Yes ☐ No
   k) Allergies; anemia or other disorder of the blood? ☐ Yes ☐ No
   l) Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? ☐ Yes ☐ No
   m) Anxiety, depression, stress or other mental, nervous, psychiatric or emotional disorder? ☐ Yes ☐ No
   n) Chronic fatigue, fibromyalgia, or Epstein-Barr virus? ☐ Yes ☐ No
   o) C-section, miscarriage, or complication of pregnancy? ☐ Yes ☐ No
   p) Any mental or physical disorder not listed above? ☐ Yes ☐ No
3. Are you currently pregnant? ☐ Yes ☐ No
4. Other than noted above, have you within the past five years:
   a) Had a checkup, consultation, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had an electrocardiogram, X-ray, or other diagnostic test? ☐ Yes ☐ No
   b) Been medically advised to have any diagnostic test, hospitalization, or surgery which was not completed? ☐ Yes ☐ No
5. Within the past ten years, have you ever:
   a) Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics; or any other drug, except as legally prescribed by a physician? ☐ Yes ☐ No
   b) Sought or received medical treatment or professional advice; or been arrested for the use of alcohol, cocaine, marijuana, narcotics or any other drug? ☐ Yes ☐ No
   c) Used alcoholic beverages? If yes, specify extent? ☐ Yes ☐ No
6. Have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
7. Have any of your immediate family members (parents, brothers and sisters), died of or been diagnosed as having; coronary artery disease, diabetes, cancer, stroke or kidney disease, prior to age 60? ☐ Yes ☐ No

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters			

8. a) Name and address of personal or attending doctor:
   _____
   _____
   _____
   b) Telephone: _____
   c) Date last consulted: _____
   Reason and any medication/treatment given:
   _____
   d) List any medications *(prescription or nonpresciption)* you are taking currently:
   _____
   _____

For each "Yes" answer, provide details. *(Identify: question number, diagnoses, dates, duration, names and addresses of all attending physicians and medical facilities. Attach additional sheet if needed.)*

UnionCentral

Application for Insurance
Fraud Notice

Unless specific state language is noted below, the following general fraud notice applies. In New York, the general 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.

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

Application for Insurance
Authorization

Authorization to Obtain and Disclose Information

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 two and one-half years from the date shown below (except MN, which is valid for two years and two months). 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.)

This Authorization complies with the HIPAA Privacy Rules.

UnionCentral

Application for Insurance
Agreement

Agreement

The undersigned represents that the statements in Part I and Part II if such Part II is required by the The Union Central Life Insurance Company ("the Company") of this application are true and complete to the best of his/her knowledge and belief. It is agreed that: (a) the only statements which are to be considered as the basis of the policy are those contained in the application or in any amendment to the application; (b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT bearing the same number as this application; **(c) if there is no prepayment made with this application, the policy will not take effect until the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II (if such Part II is required by the Company) of this application, and until the policy is delivered to the undersigned;** (d) no one except the President, a Vice President, the Secretary, or an Assistant Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements and the contract must be endorsed to so reflect; and (e) the application was signed and dated in the state indicated below. If applying for an indeterminate premium plan: (a) the premium for such plan is guaranteed for the initial guarantee period, and after such period, the current annual premium is not guaranteed and may change; and (b) the premium will never exceed the specified maximum.

Dated at: _____
City State Month Day Year

_____
Print or Type Proposed Insured Name

X _____
Signature of Proposed Insured

_____
Print or Type Name of Other Proposed Insured

X _____
Signature of Other Proposed Insured

_____
Print or Type Owner if not Proposed Insured

X _____
Signature of Owner if not Proposed Insured

_____ _____
Print or Type Agent Name Agent Union Central No.

X _____ _____
Signature of Licensed Soliciting Agent Agent State License No.

_____ _____
Print or Type Agent Name Agent Union Central No.

X _____ _____
Signature of Licensed Soliciting Agent Agent State License No.

_____ _____
Agency Name Agency No.

Taxpayer Identification Number (TIN)

Social Security Number

Employer Identification Number

Under penalties of perjury, I certify that:

1) The number shown on this form is my correct TIN (or I am waiting for a number to be issued to me); and
2) I am not subject to backup withholding either because: (a) I am exempt from backup withholding; (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.
3) I am a U.S. Person (including a U.S. resident alien).

Cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

X _____ _____
Signature of Owner, Trustee/Employer Date

UnionCentral

Application for Insurance
Agent's Statement

1. Background Information

a) How well acquainted are you with the purchaser?
- ☐ First Contact
- ☐ Well Known
- ☐ Casually
- ☐ Self
- ☐ Relative *(relationship)*:_____

b) Initial contact with purchaser?
- ☐ Friend/Relative
- ☐ Direct-Mail Lead
- ☐ Referred Lead
- ☐ Home-Office Lead
- ☐ Cold Call
- ☐ Other:_____

c) Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

2. Was this a Competitive Situation? ☐ Yes ☐ No

Competing Company _____

3. Did you receive Union Central Home Office Assistance?

☐ Yes ☐ No *(If yes, please provide details in Agent Remarks.)*

4. Life Insurance Information

a) If proposed insured is married, indicate amount of life insurance in force on spouse:$_____

b) If proposed insured is under 18 years of age:
Amount of insurance in force on life of parents:

_____

Estimate parent's worth:_____

Estimate parents income:_____

c) Are all of proposed insured's minor brothers and sisters insured for an equal amount? ☐ Yes ☐ No

_____

Purpose of Insurance:

d) Personal Life Insurance
- ☐ Survivor Needs
- ☐ Mortgage Acceleration
- ☐ Spouse Insurance
- ☐ Income Replacement
- ☐ Education Funding
- ☐ Retirement Funding
- ☐ Other *(specify)*:_____

e) Business
- ☐ Key Person
- ☐ Deferred Compensation
- ☐ Business Purchase
- ☐ Executive Bonus (Sec. 162)
- ☐ Cover Debt
- ☐ Split Dollar
- ☐ Other *(specify)*:_____

f) Estate
- ☐ Charitable Gifts
- ☐ Fund Trusts for Heirs
- ☐ Estate Tax
- ☐ Equalization between Heirs
- ☐ Other *(specify)*:_____

5. Request for Additional or Alternate Life Policy(ies)
- ☐ Alternate Policy
- ☐ Additional Policy

(If requested, provide details):

_____

_____

6. Disability Income Insurance Information

Occupational Class Quoted:
- ☐ 5AP ☐ 5A ☐ 4A ☐ 3AP
- ☐ 3A ☐ 2A ☐ A ☐ B
- ☐ Other: _____

Agent Remarks:

_____

_____

_____

7. Agent's Certification *(Must be Signed and Dated)*

I Certify that:
- I have reasonable grounds to believe the purchase of the policy applied for is suitable for the policy owner based on the information furnished by the proposed insured and/or policy owner in this application.
- A current prospectus(es) was (were) delivered to the proposed insured. (Applicable to Variable Products Only.)
- All of the sales materials used have been approved by the Home Office. (Applicable to Variable Products Only.)
- I am familiar with Union Central's Guide to Market Conduct (form UC 2231), and the sale of this product is consistent with those guidelines.
- I have verified the accuracy of the proposed insured and/or owner driver's license.
- I certify that I have truly and accurately recorded on the application all the information supplied by the applicant.
- This application was in fact signed and dated in the state indicated.

X _____

Signature of Agent:

Print Full Name of Agent:_____

Agent Number:_____

Agency Number:_____

UnionCentral

Application for Insurance
Conditional Receipt

DO NOT DETACH UNLESS PREMIUM PAYMENT IS MADE WHEN APPLICATION IS DATED AND SIGNED. DO NOT USE IF LIFE INSURANCE APPLIED FOR IS OVER $1,000,000. DO NOT USE IF DISABILITY INCOME OR DISABILITY OVERHEAD EXPENSE IS OVER $8,000 PER MONTH. PREMIUM SHOULD NOT BE ACCEPTED IF THE PROPOSED INSURED IS AGE 75 OR OLDER, OR HAS BEEN TREATED FOR HEART DISEASE, DIABETES, STROKE, OR CANCER, WITHIN THE PAST 12 MONTHS, OR HAS BEEN ADMITTED TO A MEDICAL FACILITY WITHIN THE PAST 90 DAYS.

Terms and Conditions

All of the terms and conditions of this receipt must be fulfilled for insurance to be in effect on the "coverage date"' or no insurance will be in effect under this receipt. The "coverage date"' is the date of the Part I or Part II or medical examination or other test required by published Company rules used when considering the benefits applied for, whichever date is latest.

1. Premium Payment

For Adjustable Life insurance, the premium payment taken with this application must be equal to or greater than the full initial premium. For any other life insurance, or Disability income insurance, the premium taken with this application must be equal to the full first premium for the mode of premium and benefits applied for.

2. Insurability

As of the "coverage date," a Company Underwriting Officer must find each person proposed for insurance to be an acceptable risk at standard premium rates for the benefits applied for without an exclusion or restrictive endorsement.

3. Conditional Insurance

If all of the conditions of this receipt are met, insurance under this receipt will be provided from the "coverage date" to the date the policy is delivered, subject to maximum amount limitations set out below.

4. a) **Maximum Amount** *(applicable to life insurance only)*

Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application, or in the case of Adjustable Life insurance-the initial specified amount applied for; or (b) $1,000,000 of insurance and $100,000 of accidental death benefits.

b) **Maximum Amount** (applicable to Disability Income or Disability Overhead Expense only)

Any liability of the Company under this and any other receipts may not exceed the lesser of: (a) the amount applied for in this application; or (b) $8,000 per month of Disability Income or Disability Overhead Expense.

5. Termination of Conditional Insurance

If insurance is provided under this receipt, it will terminate when the policy(ies) is/are delivered. If the application is declined, the premium paid will be refunded and there will have been no coverage provided under this receipt.

6. Suicide

If any person proposed for insurance commits suicide, the Company's liability under this receipt will be limited to a refund of the premium payment acknowledged above.

NOTICE TO APPLICANT -
PLEASE READ THIS RECEIPT CAREFULLY.

No insurance is provided under this conditional receipt unless all terms and conditions of this receipt are met. This receipt is void if the payment is made by a check or draft that is not honored when presented for payment. Also void are any modifications made to the conditions of this receipt. All premium checks must be made payable to the company. Do not make checks payable to the agent or leave checks blank.

RECEIVED from_____

this _____day of_____,

in the year of _____ , by personal or business check,

the sum of $_____

in connection with this application for insurance, which application bears the same date and number as this receipt.

X_____
(Signature of Agent)

UnionCentral

Check-O-Matic

THE UNION CENTRAL LIFE INSURANCE COMPANY, Cincinnati, Ohio, is hereby requested and authorized, subject to its approval, to draw checks, drafts or orders monthly, whether by electronic or paper means, to be charged against the checking account of:

Name of Bank Depositor _____ , _____
(Print Name as shown on Bank Records) (Depositor's Checking Acc't No. if any)

with _____ _____ (Transit Number)
(Name of Bank and Branch Name, if any) (Routing Symbol)

_____
(Address of Bank or Branch where account is maintained)

FOR THE PURPOSE OF:

(1) ☐ collecting monthly premiums payable at the Check-O-Matic premium rate for -

A. The policy applied for in an application dated _____ , _____
(Name of Proposed Insured or Annuitant)

B. Policy Number(s) _____ _____
(Name of Insured or Annuitant)

C. Day of month for withdrawals _____

(2) ☐ collecting monthly policy loan principal and interest payments of $ _____ that will be applied toward payment of policy loan(s) on policy number(s) _____. Where more than one policy loan is involved, each payment will be applied proportionately to each policy.

IT IS UNDERSTOOD THAT: Either or both of the above arrangements may be terminated by the policy owner or by the Company upon written notice. If the Bank Depositor is other than the policy owner, the Company will terminate either or both of the arrangements upon written request of such Bank Depositor. Should the Premiums cease to be paid by Check-O-Matic, the Company will accept payment of quarterly, semiannual or annual premium payments at the Company's published rates in effect as of the date of the policy as long as the interval of premium payment selected provides a minimum premium of $10.00. Dividends cannot be used to apply on Check-O-Matic premiums. If dividends are currently being used to reduce premiums, please indicate below the dividend option desired.

☐ Accumulate at Interest ☐ Purchase Additional Insurance ☐ Paid in Cash

Signature of Policy Owner _____
AND (Social Security Account Number)
Signature of Bank Depositor
Date _____ (If other than Policy Owner) _____

AGENCY OFFICE TO COMPLETE THIS SECTION

Branch Office or General Agency _____ Agency Code Number _____

By _____ Date _____

IMPORTANT MEMO TO AGENT:
To assist in magnetic ink encoding of account, a VOIDED SAMPLE CHECK on Bank Depositor's Account MUST BE ATTACHED.

CHECK-O-MATIC MEMORANDUM

(1A) **NEW ACCOUNT, CHANGE TO CHECK-O-MATIC, BANK CHANGE or ACCOUNT NUMBER CHANGE** - Prepare a COM authorization (Form UC 2178) and send the bank portion to the payor's bank. Note - If multiple applications and/or policies are involved only one 2178 is required. List in "3A" all applications pending and in "3B" all existing policies, if any, that are to be included on this account.

(1B) **NEW ACCOUNT** - To be marked if COM account is being established for the first time.

(2) **ADD TO EXISTING ACCOUNT** - No new COM authorization is required. List in "3A" all applications pending that are to be included on this account.

(3A) Full name of the proposed insured(s) _____

(3B) Full name of the insured(s) and policy number(s) on existing policies under this COM account _____

_____

(4) Is address on voided check a change of address Yes ☐ No ☐ If "Yes," Form 733-B must be completed and attached.

☐ ADD TO EXISTING ACCOUNT ☐ CHANGE TO CHECK-O-MATIC ☐ ACCOUNT NUMBER or BANK CHANGE ☐ NEW ACCOUNT

A VOIDED CHECK IS REQUIRED
STAPLE CHECK HERE

UnionCentral

Check-O-Matic

MEMO TO BANK
The attached is your depositor's authorization to honor checks, drafts or orders drawn by The Union Central Life Insurance Company as well as our Indemnification Agreement.
We appreciate your cooperation in processing this authorization.

AUTHORIZATION TO HONOR CHECKS, DRAFTS OR ORDERS DRAWN BY THE UNION CENTRAL LIFE INSURANCE COMPANY

Name of Bank Depositor _____
(Print name as shown on Bank Records)

_____ _____ (Transit Number) (Routing Symbol)
(Checking Account Number, if any)

_____
(Name of Bank and Branch name, if any)

_____
(Address of Branch or Branch where account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my Account checks, drafts or orders, whether by electronic or paper means, drawn on my account by THE UNION CENTRAL LIFE INSURANCE COMPANY to its own order. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such order.

I agree that your treatment of each such item, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such check, draft or order be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

The bank shall be under no obligation to furnish me with any special advice or notice in writing or otherwise of the payment and charge of such checks, drafts, or orders to my account.

THE UNION CENTRAL LIFE INSURANCE COMPANY is instructed to forward this authorization to you.

_____ _____
(Date) (Signature of Bank Depositor - as shown on Bank Records for the account to which this Authorization is applicable)

INDEMNIFICATION AGREEMENT

To: Bank named above

In consideration of your compliance with the request and authorization of the depositor named above, The Union Central Life Insurance Company agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether by electronic or paper means, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expense reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even through dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

THE UNION CENTRAL LIFE INSURANCE COMPANY

By

John H. Jacobs
President

David F. Wiethuchter
Secretary

UnionCentral

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Examiner _____

Address _____

To determine your insurability, the Insurer named above, Union Central, has requested that you provide a sample of your body fluids for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claims review process. If the HIV test is positive the results will be reported to the local health department or the State Department of Health, and if the Insurer is a member of the Medical Information Bureau, (MIB, Inc.), the Insurer may report the results in a generic code which signifies only non-specific test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notifications will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results, which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS and AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice of Consent For Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the collection of body fluids, the testing of those fluids, and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize Union Central to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Physician's Name _____

Physician's Address _____

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured _____ Date of Birth _____

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

UnionCentral

Notice to Applicant Regarding Replacement of Health Insurance

According to your application, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by The Union Central Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though you policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: .

_____
(Date)

_____
(Applicant's Signature)