One Forethought Center
Batesville, IN 47006
Phone: 888-606-6372
Interview: 800-737-6972
Fax: 877-432-1646

FORE THOUGHT®

FAX

TO: Forethought Life Insurance Company

Agent:

Fax #: 1-877-432-1646

Date:

Phone: 1-888-606-6372

Agent Fax #:

Re: Forethought® Freedom℠ Application(s)

Total Pages:

FAX APPLICATION TRANSMITTAL FORM

Comments: Legibly print the name of the applicant, premium collected, agent's name, agent's writing number, agent's fax and phone number, and the number of pages being faxed including the fax application transmittal form. **Be sure to include the required HIPAA form along with the application.** Fax a maximum of 5 applications at one time including a copy of the premium check. If initial payment is not an Electronic Funds Transfer, mail the check to:

Forethought Life Insurance Company
P.O. BOX 148
BATESVILLE, IN 47006

AGENT'S NAME: _____

AGENT'S NUMBER: _____ AGENT'S PHONE NUMBER: _____

APPLICANT'S NAME	PREMIUM COLLECTED	DO NOT USE – PROCESSING CENTER ONLY	DO NOT USE – PROCESSING CENTER ONLY

FORE THOUGHT®

APPLICATION FOR LIFE INSURANCE
PART 1

_____ Reference Number

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED *(Please Print Using Black Ink)*

First Name	Middle Initial	Last Name		
☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Age	State of Birth	Social Security Number - -
Are You a U.S. Citizen ☐ Yes ☐ No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE				
Mailing Address			Residential Address (if different than Mailing Address)	
City	State	Zip Code	Occupation	
Phone Number (home) ( )	Phone Number (work) ( )	E-mail Address		
Have you smoked cigarettes in the last 12 months? ☐ **Yes** ☐ **No**				

2. OWNER *(Complete only if the Owner and Proposed Insured are different.)*

First Name	Middle Initial	Last Name	
☐ Male ☐ Female	Relationship to Proposed Insured		Social Security Number - -
Are You a U.S. Citizen ☐ Yes ☐ No IF NO, PROVIDE PERMANENT RESIDENT CARD NUMBER OR VISA TYPE			
Mailing Address		Residential Address (if different than Mailing Address)	
City	State	Zip Code	
Phone Number (home) ( )	Phone Number (work) ( )	E-mail Address	

3. BENEFICIARY INFORMATION *(Beneficiary proceeds will be split equally if no percentages are provided.)*

Primary

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

Contingent

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

First Name	Middle Initial	Last Name	
Age	Relationship to Proposed Insured	Social Security Number - -	Percentage

4. INSURANCE PLAN INFORMATION

Plan of Insurance:
- ☐ Level Death Benefit
- ☐ Graded Death Benefit
- ☐ Return of Premium

Billing Mode:
- ☐ Annual
- ☐ Semi Annual
- ☐ Quarterly
- ☐ Monthly EFT

Face Amount $ _____

Riders: ☐ _____ ☐ _____ ☐ _____

Initial Premium $ _____

- ☐ Check with Application
  Make check payable to Forethought Life Insurance Company
- ☐ Draft First Premium
  Draft EFT account for initial premium on _____

5. BANK DRAFT AUTHORIZATION – *Please attach a voided personal check*

Electronic Funds Transfer (EFT)
- ☐ Checking
- ☐ Savings

Custom Date _____ **(1st thru 28th of the month)**

Account # _____

ABA Routing/Transit # _____

_____ **(** **)** _____

Name of Financial Institution **Phone # of Financial Institution**

_____

Social Security Number of Account Holder

Automatic Payment Authorization – *Must be completed for EFT*

I authorize Forethought Life Insurance Company ("FLIC") to charge/deduct my insurance premium from my account. This authorization is to remain in effect until I revoke my automatic monthly premium payment by notifying FLIC.

_____

Payor's Signature – ***as it appears on the bank account*** Date

6. REPLACEMENT INFORMATION

1. **Does the proposed insured currently have any life insurance in force?** ☐ Yes ☐ No
2. **Will this insurance replace any life insurance in force?** ☐ Yes ☐ No
   If Yes, complete #3 and submit replacement forms required by your state.

3. Company Name	Face Amount	Policy Number

7. ELIGIBLE GRANDCHILDREN *(to be covered by Grandchildren's Benefit)*

Grandchild's Full Name	Date of Birth	Grandchild's Full Name	Date of Birth

8. 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.

STATE REQUIRED NOTICES

AR, KY, LA, MD, NH, NM, RI, TX and WV 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.

AK, DE, OH, and OK Residents
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ID and IN Residents
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

ME, TN, and WA 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 include imprisonment, fines and denial of insurance benefits.

CA Residents – Reg. 789.8
The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

MN Residents
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

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.

9. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc. (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

10. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while I am living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature	Date	Signed At (City, State)
Owner Signature (if other than Proposed Insured)	Date	Signed At (City, State)
Licensed Agent Signature	Date	Signed At (City, State)

11. AGENT DECLARATIONS AND SIGNATURES

Primary Agent Name (Print)			
Address	City	State	Zip Code
Phone Number (home) ( )	E-mail Address		
Business or Institution Name	Business or Institution Phone Number ( )		
License Number	Agent Number		

I declare that: (a) the application was signed and dated by the Proposed Insured and by the Owner, if not the Proposed Insured, after all answers and information were recorded herein; and (b) I have truly and accurately recorded on this form all of the information provided by the Proposed Insured and the Owner, if not the Proposed Insured.

1. Did you personally see the Proposed Insured? ☐ **Yes** ☐ **No**
   If yes, what type of photo ID was used to verify identity?
   ☐ **Drivers license** ☐ **Passport** ☐ **Other** _____
2. Will this policy replace or change any existing life insurance or annuities? If yes, complete the appropriate state Replacement form and submit it with the application. ☐ **Yes** ☐ **No**
3. Did you give the Proposed Insured a copy of the Information Practices and MIB Disclosure? ☐ **Yes** ☐ **No**

If the Owner is other than the Proposed Insured, what type of photo ID was used to verify the Owner's identity?

☐ **Drivers license** ☐ **Passport** ☐ **Other** _____

What is the best time and phone number to contact the Proposed Insured?

Time _____ Phone Number (_____)_____ Time Zone _____

Mail completed policy to: ☐ **Agent** ☐ **Policyowner**

Primary Agent Signature	Date	Signed At (City, State)
Print Name	Commission %	
Agent Signature	Date	Signed at (City, State)
Print Name	Commission %	Agent Number

FORETHOUGHT LIFE INSURANCE COMPANY HOME OFFICE USE ONLY

Application for Life Insurance

Forethought Life Insurance Company
One Forethought Center
P.O. Box 148
Batesville, IN 47006-0148

DISCLOSURES

TO BE GIVEN TO THE PROPOSED INSURED
DO NOT SEND TO HOME OFFICE

MEDICAL INFORMATION BUREAU ("MIB") NOTICE Information regarding your insurability will be treated as confidential. FLIC or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. FLIC, 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES This application is our major source of information about the Proposed Insured. As part of our routine underwriting procedure, we will occasionally obtain an investigative consumer report which will provide applicable personal information concerning character, general reputation, personal characteristics, and mode of living. This information may be obtained through other parties, including personal interviews with your friends, neighbors, and associates. In some circumstances, this information may be disclosed to third parties without your specific authorization, but only for certain limited purposes related to the conduct of our business with respect to this application. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

ELECTRONIC FUNDS TRANSFER Effective March 31, 2002, the NACHA Operating Rules, the Electronic Funds Transfer Act, and Federal Reserve's Regulation E were modified to permit the conversion of a paper check to electronic data. By sending a check for payment on your policy, you will be authorizing the use of the information on your check to make a one-time electronic debit from the account on which the check is drawn. This electronic debit, which may post to your account as early as the date your check is received, will be only for the amount of your check. The transaction will appear in the electronic payment area of your checking account or credit union statement. Your paper check will not be returned. It will be imaged and the original destroyed as required by the above regulation. An image of the check will be available upon request.

Important Notice

Part 2 – Medical Questionnaire is now included in **all** application packets. Part 2 should **only be completed if your client does not agree to voice signature**. If your client agrees to a voice signature and you are submitting the application with your client, **you do not need to complete Part 2.**

FORE THOUGHT®

APPLICATION FOR LIFE INSURANCE
PART 2 MEDICAL QUESTIONNAIRE

Reference Number _____

Forethought Life Insurance Company One Forethought Center Batesville, IN 47006-0148

1. PROPOSED INSURED *(Please Print Using Black Ink)*

Name (First, Middle Initial, Last)		Date of birth (mm/dd/yyyy)
Mailing Address		
City	State	Social Security Number - -

2. HEALTH QUESTIONS

1. What is your current Height? _____ ft _____in: Weight? _____ lbs

2.	**Do you require assistance in performing the Activities of Daily Living (ADL's) of eating, bathing, toileting, transferring or dressing or are you confined to a wheelchair?**	☐ Yes ☐ No
3.	**Are you currently:**	
	a. Hospitalized or confined to a bed, nursing home, psychiatric facility, receiving home health care or hospice care or are you currently incarcerated?	☐ Yes ☐ No
	b. Receiving kidney dialysis, chemotherapy or radiation, or using oxygen equipment to assist in breathing (other than for sleep apnea)?	☐ Yes ☐ No
4.	**Have you:**	
	a. Been medically diagnosed as having a life expectancy of 12 months or less?	☐ Yes ☐ No
	b. Had a heart, lung, liver or kidney transplant or has one been recommended to you?	☐ Yes ☐ No
	c. Within the last 12 months, been advised to have any medical procedure, diagnostic test or surgery that has not yet been done or for which the results have not been received?	☐ Yes ☐ No
	d. Been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
5.	**Have you been medically diagnosed, treated for, advised to have treatment for, taken medication, or been prescribed medication for:**	
	a. Alzheimer's disease, dementia, chronic memory loss?	☐ Yes ☐ No
	b. Lou Gehrig's disease (ALS), kidney or liver failure, or end stage kidney disease?	☐ Yes ☐ No
	c. Congestive heart failure or cardiomyopathy within the last 24 months?	☐ Yes ☐ No
6.	**In the last 12 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	☐ Yes ☐ No
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery or aneurysm?	☐ Yes ☐ No
7.	**In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Any internal cancer, brain tumor, leukemia, melanoma, Hodgkin's disease or other lymphoma, cirrhosis of the liver or alcohol or drug dependency?	☐ Yes ☐ No
	b. Diabetes with complications including, eye or kidney disorders, diabetic coma, insulin shock or amputation due to disease?	☐ Yes ☐ No
8.	**Do you have diabetes in combination with a stroke, TIA, or heart disease (including heart attack and heart surgery); have you had multiple strokes, TIA's or heart attacks, or do you have heart disease with a history of a stroke or TIA?**	☐ Yes ☐ No

9.	**In the last 24 months have you been medically diagnosed, treated for, advised to have treatment for, taken medication or been prescribed medication for:**	
	a. Coronary artery disease, heart attack, angina, heart surgery (including bypass, angioplasty and stent placement) or heart valve replacement?	☐ **Yes** ☐ **No**
	b. Stroke or transient ischemic attack (TIA), carotid artery surgery, aneurysm or any irregular heartbeat, such as atrial fibrillation (including a pacemaker or defibrillator)?	☐ **Yes** ☐ **No**
	c. Depression, bipolar disorder, schizophrenia or other psychosis?	☐ **Yes** ☐ **No**
	d. Parkinson's disease, multiple sclerosis or chronic hepatitis?	☐ **Yes** ☐ **No**
	e. Emphysema, chronic obstructive pulmonary disease (COPD), asthma or chronic bronchitis?	☐ **Yes** ☐ **No**
10.	**Do you have diabetes that has required insulin treatment within the last 5 years?**	☐ **Yes** ☐ **No**
11.	**In the last 12 months, have you had a seizure or convulsion?**	☐ **Yes** ☐ **No**
12.	**Have you been hospitalized 2 or more times in the last 12 months for any reason?**	☐ **Yes** ☐ **No**

3. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, the Proposed Insured, authorize Forethought Life Insurance Company to obtain protected health information including prescription history, for the purpose of determining my eligibility for insurance, from any licensed physician, medical practitioner, hospital, clinic, the Veteran's Administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc (MIB), insurance companies, consumer reporting agencies and authorize said persons, firms or entities to furnish such information to Forethought Life Insurance Company.

Health information will not be re-disclosed without my authorization, unless permitted by law, in which case it may not be protected under federal privacy rules.

A photographic copy of this authorization shall be as valid as the original. I have a right to receive a copy of this authorization upon request. This authorization shall be valid for two years from the date of my signature below, and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above.

4. AGREEMENT

I agree that no insurance shall be in effect until: (a) a policy has been issued, and (b) the first premium is paid while living and my insurability remains unchanged and then only if I am actually in the state of health represented in this application.

I state that the answers set forth in this application are full, complete and true to the best of my knowledge and belief. The answers are the basis of any insurance issued.

I acknowledge that I have received the Notice of Information Practices and the MIB disclosure notice.

I agree that a verbal confirmation may be requested for this application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

All statements made by me or on behalf of me shall be deemed to be representations and not warranties.

Proposed Insured Signature

Date

Proposed Insured Printed Name

Examiner/Interviewer Signature

Forethought Life Insurance Company
One Forethought Center
Batesville, Indiana 47006

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Forethought Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the MIB, Inc., the Veterans Administration, other insurance companies, or anyone else to release any and all records and information to be exchanged between Forethought Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, testing, treatment, or advice for the following: alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, mental disease, genetic disorders, pharmacy prescriptions, HIV or AIDS, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. I understand Forethought Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Forethought Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Forethought Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)	Name of Proposed Insured B (please print)
Signature of Proposed Insured	Signature of Proposed Insured B
Date	Date

RETURN TO COMPANY

FORETHOUGHT LIFE INSURANCE COMPANY
ONE FORETHOUGHT CENTER
BATESVILLE, INDIANA 47006
INSURANCE – 800/331-8853
ANNUITIES – 877/244-7526

NOTICE TO APPLICANTS
REGARDING REPLACEMENT OF LIFE INSURANCE

THIS NOTICE IS FOR YOUR PROTECTION AND IS REQUIRED BY REGULATIONS OF THE MICHIGAN COMMISSIONER OF INSURANCE. PLEASE READ IT CAREFULLY.

Dropping or changing your existing life insurance to replace it with a new life insurance policy may be disadvantageous because:

A company can deny a claim during the first two years if it can be shown that you withheld information from your application which was important to the decision of whether to insure you. This is called the "CONTESTABLE PERIOD." If you drop or change policies, you may have to go through the two year period again.

You may pay HIGHER RATES for identical coverage because of your age. Life insurance rates go up as you get older.

BEFORE YOU DROP, CHANGE OR CASH IN YOUR PRESENT INSURANCE and apply for new insurance, you should:

1. Compare the policy BENEFITS and OPTIONS. The agent is required by law to provide you with all pertinent facts of the change and the insurance company you are considering must notify the company that issued your existing policy.

2. Be aware that you may be required to provide EVIDENCE OF INSURABILITY. If your health condition has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy, or be denied coverage.

3. Compare the LOAN INTEREST RATE. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy.

4. Find out if the existing policy and/or the proposed policy offers DIVIDENDS OR EXCESS INTEREST. Dividends or excess interest can have a significant impact on net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.

5. CONTACT THE AGENT OF YOUR PRESENT COMPANY. Your present company can often make changes in your existing insurance on terms which are more favorable to you than can another company.

6. Find out if there are income or estate tax consequences if you drop or change your present policy.

You should not drop or change your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. REMEMBER YOU HAVE THIRTY DAYS AFTER RECEIPT OF THE POLICY TO CANCEL AND OBTAIN A FULL REFUND.

Applicant's Signature **Date**

FORETHOUGHT LIFE INSURANCE COMPANY
ONE FORETHOUGHT CENTER
BATESVILLE, INDIANA 47006
INSURANCE – 800/331-8853
ANNUITIES – 877/244-7526

INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM FORETHOUGHT LIFE INSURANCE COMPANY MAY REPLACE OR ALTER EXISTING LIFE INSURANCE.

The following **EXISTING** policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	**Insured as it appears on the policy**	**Policy Number**

The **PROPOSED** policy is:

_____ $ _____
Type of policy - generic name Face amount

_____
Signature of Applicant Date

_____
Address of Applicant City State Zip

I certify that this form and the Notice to Applicants Regarding Replacement of Life Insurance were given to and signed by

_____
(applicant - please print or type)

prior to taking an application and that I am leaving a signed copy for the applicant.

_____
Date Agent's Signature

_____
Address City State Zip