OXFORD LIFE INSURANCE COMPANY
2721 North Central Avenue • Phoenix, Arizona 85004
(866) 641-9999

ASSURANCE
FINAL EXPENSE WHOLE LIFE INSURANCE

INDIVIDUAL LIFE INSURANCE APPLICATION

TELEPHONE INTERVIEW 1-888-801-5123

Section A — Personal Information

PROPOSED INSURED

Name (First, MI, Last)				
Address, City, State, Zip Code				
SSN, Tax I.D.# or Green Card Number	Gender	Date of Birth	Birth State	Phone Number ( )
Email Address	U.S. Citizen ❑ Yes ❑ No If no, are you a Permanent U.S. Resident ❑ Yes ❑ No			

OWNER (If other than Proposed Insured)

Owner's Name (First, MI, Last)	Owner's Address, City, State, Zip Code	
Owner's SSN, Tax I.D.# or Green Card Number	Relationship	Phone Number ( )

Does the Proposed Insured and/or Owner, have any existing life insurance or annuity coverage? ❑ Yes ❑ No
Is this policy being purchased to replace any existing life insurance or annuity coverage? ❑ Yes ❑ No If Yes, please list:

Company	Policy No.	Address, City, State, Zip Code

Has the Owner, Proposed Insured or Beneficiary entered into or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in this policy? ❑ Yes ❑ No If yes, no coverage will be issued.

BENEFICIARY

Primary	Address, City, State, Zip Code	Relationship	SSN	%
Primary	Address, City, State, Zip Code	Relationship	SSN	%
Contingent	Address, City, State, Zip Code	Relationship	SSN	%
Contingent	Address, City, State, Zip Code	Relationship	SSN	%

Section B — Policy Information

PREMIUM AMOUNT $_____ **FACE AMOUNT $** _____

PAYMENT FREQUENCY: ❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually
Additional out-of-pocket costs may apply should you choose to pay your premiums monthly, quarterly or semi-annually.

Check here if Owner does **not** want the Automatic Premium Loan provision: ❑

Section C — If any question in Section C is answered "Yes", or if height and weight exceeds the maximum range, NO COVERAGE CAN BE ISSUED.	**ANSWER FOR PROPOSED INSURED**
1. What is your height and weight?	H_____ W_____
2. Have you had, or been medically advised to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure or do you have paralysis of two or more extremities?	❑ Yes ❑ No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	❑ Yes ❑ No
4. Are you currently: hospitalized, confined to a bed or nursing facility, or using oxygen equipment to assist in breathing, or receiving Hospice Care?	❑ Yes ❑ No
5. Have you been treated for insulin shock, diabetic coma, or ever taken insulin shots prior to the age of 50 or were you diagnosed with Diabetes prior to age 30?	❑ Yes ❑ No
6. Have you ever been medically diagnosed, treated, or taken medication for: congestive heart failure (CHF), cardiomyopathy, Alzheimer's, dementia, organic brain syndrome, schizophrenia, bipolar disorder, mental incapacity, Lou Gehrig's disease (ALS), or Huntington's disease?	❑ Yes ❑ No
7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	❑ Yes ❑ No
8. Within the past 24 months have you been diagnosed with internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA) or have you had an amputation caused by any disease?	❑ Yes ❑ No
9. Have you had more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer?	❑ Yes ❑ No
10. Within the past 24 months have you:	
a. been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing?	❑ Yes ❑ No
b. been diagnosed as having, been treated for or hospitalized for: heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain?	❑ Yes ❑ No
c. had Hodgkin's Disease, cirrhosis, liver disease, or systemic lupus (SLE)?	❑ Yes ❑ No
d. had any neuromuscular disease (including cerebral palsy, multiple sclerosis, grand mal seizures, or Parkinson's disease)?	❑ Yes ❑ No
11. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation?	❑ Yes ❑ No
12. Within the last 5 years have you been treated for, been advised to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or attempted suicide?	❑ Yes ❑ No
13. Have you been declined or postponed for life or health insurance in the past two years?	❑ Yes ❑ No
14. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as dressing, eating, bathing, incontinence, toileting, taking medications, or moving without any type of physical assistance?	❑ Yes ❑ No
Section D – If any question in Section D is answered "Yes", it may not necessarily exclude coverage.	
15. Are you taking medication for any impairment in Section C?	❑ Yes ❑ No
16. Have you used any nicotine based products in the past 12 months?	❑ Yes ❑ No
17. Have you applied for life insurance with any other insurance companies in the last two years?	❑ Yes ❑ No
18. Proposed Insured's driver's license number_____ State_____	❑ None

Section E — Statements and Authorizations

PROPOSED INSURED'S STATEMENT (*or Owner if legal representative)*

I have read and understood this Application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The representations in Sections A, B, C, D and E are true. I agree the policy shall not be in effect until it has been issued by Oxford Life Insurance Company ("the Company") and the premium is paid during my lifetime. I understand that the Producer has no authority to approve this Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date signed in the policy and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company. _____ Proposed Insured's Initials

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, the Medical Information Bureau (MIB), pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give Oxford Life Insurance Company or its reinsurers any information they have about my health, including confidential HIV-related information. I acknowledge receipt of the Medical Information Bureau Pre-Notice on page 7. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

WARNING

FRAUD NOTICE

Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

I have read, understand, and acknowledge the Fraud Notice. _____ Proposed Insured's Initials _____ Owner's Initials

MISREPRESENTATION NOTICE

If your answers to the questions in the application are incorrect or untrue, Oxford Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary (ies).

I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied on to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy. _____ Proposed Insured's Initials _____ Owner's Initials

Proposed Insured's Signature	Owner's Signature	Date

Section F — Producer Only

PRODUCER'S STATEMENT

To the best of my knowledge and belief the Proposed Insured and/or Owner ❑ **does** ❑ **does not** have any existing life insurance or annuity coverage and the life insurance applied for ❑ **will** ❑ **will not** replace any existing life insurance or annuity coverage. I certify that I have verified the personal information of the Applicant. I further certify that any information recorded by me on this Application is true and accurate to the best of my knowledge and that the Proposed Insured and Owner seemed to me to be lucid and to fully understand all of the questions on this Application. I certify to the best of my knowledge that the Owner or Proposed Insured is not being paid cash or promised services as an inducement to enter into this insurance transaction and to my knowledge, this insurance transaction will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Writing Producer's Signature	Producer's Printed Name / Producer's Number	Date

PRODUCER USE ONLY IF REQUESTING COMMISSION SPLITS

Producer's Printed Name	Producer's Number	Split
		%
Producer's Printed Name	Producer's Number	Split
		%

MAIL POLICY TO: ❑ **Owner** ❑ **Producer**

OXFORD LIFE INSURANCE COMPANY
2721 North Central Avenue • Phoenix, Arizona 85004
(866) 641-9999

ASSURANCE FINAL EXPENSE WHOLE LIFE INSURANCE

ASSURANCE – FINAL EXPENSE PRE-AUTHORIZED WITHDRAWAL PLAN

Complete the following information for initial and future recurring automatic withdrawals of premium payments

I, the undersigned, agree that I want all premiums withdrawn from the account listed below in an amount sufficient to pay the premium due for the insurance policy. Additionally, I hereby authorize and request Oxford Life Insurance Company to initiate electronic debit entries or effect a change by any other commercially accepted practice to my account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this Authorization in no way affects the terms of the policy, other than the frequency of payment and I understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any non forfeiture provision of the policy. This Authorization may be terminated by either party by giving written notice to the other.

Premium Amount to Withdraw $ _____ ❒ Monthly ❒ Quarterly ❒ Semi-Annually ❒ Annually

The effective date and draft date must be the same. If no effective/draft date is designated, the policy's effective date and initial draft date will be the date that the application was received by Oxford Life.
Future draft dates must occur within 30 days of application date. Please select the draft date you prefer.

Policy Effective/Draft Date (Between the 1st and 28th): Month: _____ Day: _____

Bank Account Information:

Bank Name and Phone Number: _____

Bank Address: _____

Payor Name: _____

Bank Routing Number: _____ Account Number: _____

Type of Account: ❒ **Savings** (write routing and account numbers below and circle the corresponding numbers)
❒ **Checking** (attach void check)

Bank Routing Number									Bank Account Number														
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

FOR CHECKING ACCOUNTS
TAPE COPY OF VOIDED CHECK HERE

PAYOR SIGNATURE: (as on financial institution's records). A copy of this document sent via electronic transmission is as valid as the original.

× _____ Date _____

This authorization complies with the HIPAA Privacy Rule

HIPAA Authorization for Release of Health Related Information

Name(s) of Primary Proposed Insured/Patient _____ Date of Birth _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy, pharmacy benefit manager; medical facility; insurance company; insurance support organization (such as MIB Group, Inc. or any of its members or affiliates); or other health care provider that has provided payment, treatment or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers; employees; and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol; drugs; and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes.

This protected health information can be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization will remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company ***(Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004).*** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application; or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Primary Proposed Insured/Personal Representative _____ Date _____

If signed by an individual's Personal Representative, describe authority to sign on behalf of the individual:

❑ Power of Attorney ❑ Other (please describe): _____

CONDITIONAL RECEIPT

PLEASE READ THIS CAREFULLY. This Conditional Receipt will not become effective unless each of the following conditions are met:

1) The premium is paid according to the method of premium payment selected in the application in an amount equal to or greater than the minimum required by the Policy; and is received by the Company.
2) All underwriting and application requirements are completed no more than 45 days after the date of this Receipt;
3) There is no material misrepresentation in the Application, telephone or other interviews, or medical information provided to the Company and
4) On the effective date, the Proposed Insured is insurable for the insurance requested in the Application.

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company is limited to a full refund to the Owner of all premiums received by the Company.

In the event of an adverse underwriting decision, the Company will mail notice to the Owner of the rejection of the Application for insurance and refund the premium, thereby terminating this Receipt. This Receipt provides no insurance for riders or additional benefits.

All checks must be made payable to Oxford Life Insurance Company. Do not make checks payable to the Producer or leave payee blank.

The Company's liability is limited to a refund of the premium paid.

I have advised the Proposed Insured and Owner of the terms, conditions, and limitations of this Conditional Receipt. If the premium is paid by Pre-Authorized Withdrawal Plan, the Payor has completed the form. If the premium is received by check, I have received from _____ a check in the amount of $_____. The Application bears the same date as this Receipt. I acknowledge that no producer or broker is authorized to alter or waive the terms of this Receipt, or pass on insurability.

_____	_____	_____
Dated at (City & State)	On (Date)	Producer's Signature

LEAVE THIS PAGE WITH OWNER IF PAYMENT IS MADE WITH APPLICATION.

PRIVACY NOTICE

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), like other insurance companies, sometimes evaluates the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth and phone number may be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

You have the right to be told about and to copy, if you wish, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT OXFORD LIFE INSURANCE COMPANY, 2721 NORTH CENTRAL AVENUE, PHOENIX, AZ 85004-1172, OR VISIT WWW.OXFORDLIFE.COM.

FAIR CREDIT REPORTING ACT NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB PRE-NOTICE – Proposed Insured

Information regarding Your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, that 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, the MIB, upon request, will supply Oxford Life Insurance Company with the information in its file.

Upon receipt of a request from You, the 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 the MIB's file, you may contact the MIB 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: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Oxford Life Insurance Company, or its reinsurers, may also release information in its file to MIB and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

LEAVE THIS PAGE WITH OWNER

For Use With Life Insurance Applications