Application for Individual Life Insurance (Please Print. Use black or blue ink)

Family Benefit Life Insurance Company (FBLIC), 7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133

Telephone Interview Completed: ☐ Yes ☐ No

(888) 995-7722 Order # _____

Section 1:

1. Full Name of Proposed Insured: First_____ MI_____ Last_____

Sex at birth: _____ DOB: ____/____/____ State or Country of Birth: _____ Age: _____ SSN: ____-____-____ Marital Status: _____

Residence Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ E-Mail: _____

2. Is the Proposed Insured a U.S. citizen? ☐ Yes ☐ No If **No**, is the Proposed Insured a permanent legal U.S. Resident? ☐ Yes ☐ No

Permanent Resident ID # _____ Expiration Date _____

3. Owner (If other than Proposed Insured):

Name _____ SSN or TIN: ____-____-____ Phone: _____

Address: _____ Relationship: _____
Street City State Zip

4. Send Premium Notices to: ☐ Insured ☐ Owner ☐ Other (If Other) Name: _____

Address: _____ Relationship: _____
Street City State Zip

5. Plan Applied For:

☐ Simplified Issued ☐ Graded Benefit	☐ Non-Tobacco ☐ Tobacco	Automatic Premium Loan: ☐ Yes ☐ No	Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT

Face Amount: $ _____	Modal Premium: $ _____	Premium Collected: $_____ or ☐ None-Draft 1st Premium (Checks Must be made payable to Family Benefit Life Insurance Company)

Issue Month (Jan.-Dec.): _____ Issue Date (1st — 28th): _____ or ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

6. Does the Proposed Insured and/or Owner have any existing life insurance or annuity coverage? ☐ Yes ☐ No

Will any existing insurance or annuity policy with another company be discontinued or changed if the insurance applied for is issued? ☐ Yes ☐ No

(If yes, give details.) Company: _____ Policy #: _____ Coverage Amount: _____ Year Issued _____

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7. Please provide the name of the doctor, practitioner, or health care facility that can provide the most complete and up-to-date medical information regarding the health of the Proposed Insured.

Primary Care Physician or Facility _____

Address: _____
Street City State Zip

Date last seen: _____ Phone: _____

8. Beneficiaries: Percentages for each beneficiary class (Primary and Contingent) must total 100%.

Primary _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

Additional Information:

Section 2:

Health History:

1. Proposed Insured's Height_____Weight_____ In the Past year any ☐ gain ☐ loss_____lbs.
2. Have you used tobacco, nicotine products, marijuana, electronic cigarette, or vaping pen/device in any form in the past 12 months? ☐Yes ☐No
3. Have you ever received or been given medical advice by a medical professional that you need to receive an organ or tissue transplant? ☐Yes ☐No
4. Have you ever been diagnosed or treated by a medical professional as having: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV (Human Immunodeficiency Virus) virus? ☐Yes ☐No
5. Have you ever been diagnosed by a medical professional with a terminal illness, end stage disease, congestive heart failure or cardiomyopathy? ☐Yes ☐No
6. Have you ever been diagnosed by a medical professional for or taken medication for: dementia, Alzheimer's disease, mental incapacity, Downs Syndrome, Huntington's disease, Lou Gehrig's disease (ALS), cystic fibrosis, cerebral palsy, muscular dystrophy, or sickle cell anemia? ☐Yes ☐No
7. Are you currently, or within the past 6 months have you been: hospitalized, bedridden, used oxygen to assist in breathing, confined to a wheelchair, nursing home, hospice, received home health care or been on dialysis? ☐Yes ☐No
8. Within the past 12 months have you been diagnosed by a medical professional for, or been hospitalized for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind (pacemaker, heart valve replaced, bypass, angioplasty, stent implant) to improve circulation to the heart or brain? ☐Yes ☐No
9. Within the past 12 months have you been: hospitalized two or more times, or been advised by a medical professional to have surgery, hospital confinement, or nursing facility confinement and have not done so? ☐Yes ☐No
10. Within the past 24 months have you been diagnosed or treated by a medical professional for, or taken medication for: internal cancer, leukemia, or melanoma? ☐Yes ☐No
11. During the past 24 months have you been: advised by a medical professional to have any diagnostic testing recommended, except for an HIV test, which has not been completed, or for which the results have not yet been received, or had or been advised to have treatment or counseling for alcohol or drug abuse? ☐Yes ☐No
12. During the past 24 months have you been treated by a medical professional for: insulin shock, diabetic coma, amputation caused by disease, or have you ever taken insulin shots prior to age 40? ☐Yes ☐No

If any answers to questions 3-12 are "YES", Proposed Insured is not eligible for any coverage.

13. During the past 24 months have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind (pacemaker, heart valve replaced, bypass, angioplasty, stent implant) to improve circulation to the heart or brain? ☐Yes ☐No
14. Have you ever been diagnosed as having: multiple sclerosis, epilepsy, schizophrenia, Parkinson's, chronic kidney disease or failure, systemic lupus, hepatitis B or C, cirrhosis of the liver, liver disease, liver failure or lung impairments(including chronic obstructive pulmonary disease (COPD), chronic asthma, chronic bronchitis, emphysema or fibrosis)? ☐Yes ☐No
15. Have you ever been diagnosed with diabetes and also been diagnosed with, or been advised by a member of the medical profession to receive treatment for: nephropathy (kidney), neuropathy (nerve), or retinopathy (eye)? ☐Yes ☐No

If any answers to questions 13-15 are "YES", Proposed Insured may qualify for Graded Death Benefit.

Please underline the specific impairment or disease for any question answered yes. Specify question number and provide details below.

ACKNOWLEDGEMENTS: I have read the completed application in its entirety. I agree that this application will be the basis for, and will become part of the policy, if issued. The above representations are true to the best of my knowledge and belief. Any material misrepresentation or misstatement contained herein may render any policy issued as a result of this application void from its inception. I agree the policy shall not be in effect until it has been issued by Family Benefit Life Insurance Company, and the initial premium has been paid. I further agree and understand that no insurance will be effective until the date stated in the policy and provided that there has been no change to the Proposed Insured's health between the date this application was signed, and the issue date of this policy. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions.

I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth, and tax payer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice. ☐Yes ☐No

I acknowledge that I paid the Agent $_____in initial premium in exchange for the Conditional Receipt attached to this application. ☐Yes ☐No

I acknowledge receipt of the Accelerated Benefit Rider Summary and Disclosure Statement. ☐Yes ☐No

FRAUD 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.

Signature of Proposed Insured:_____Date:_____

Signature of Proposed Owner (if other than Insured):_____Signed at:(City & State)_____

AGENT CERTIFICATION: I certify that I have asked the Proposed Insured all of the questions on this application and have accurately recorded them. I also certify that replacement of existing insurance ☐is or ☐is not involved.

Is any agent a relative of the Proposed Insured? ☐Yes or ☐No Relationship:_____Send Policy to: ☐ Agent or ☐Owner

Agent:_____Agent Code:_____Agent Signature:_____%_____

Agent:_____Agent Code:_____Agent Signature:_____% _____

☐ **Trinity Life Insurance Company**
☐ **Family Benefit Life Insurance Company**

Administrative Office:
PO Box 5205 Frankfort, KY 40602-5205
Phone: 866-440-1357 Fax: 502.875.7084

REQUEST FOR PREAUTHORIZED TRANSFER PLAN (PAT)

AUTHORIZATION AND SIGNATURE

I hereby request and authorize any of the Companies named above to pay and charge to my account checks and electronic fund transfers (EFTs) drawn on my account by and payable to the order of the Company provided there are sufficient collected funds in my account to pay such checks and EFTs upon presentation. I agree that the Company's rights in respect to each check and EFT shall be the same as if it were a draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until the Company actually receives such notice. I agree that the Company shall be fully protected in honoring any such check or EFT.

I further agree that if any such check or EFT is dishonored, whether with or without cause and whether intentionally or inadvertently, the Company shall have no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date:_____ _____ _____

	Account Holder's name typed or printed EXACTLY as it appears on account	**Account Holder's signature EXACTLY as it appears on account**

PREAUTHORIZED TRANSFER PLAN DATA

☐ **Apply to attached application** ☐ **Apply to existing policies listed below**

Insured's Name (First, Last) _____ _____
Existing Policy Numbers _____ _____

PREMIUM PAYMENT INFORMATION

As a convenience to me, I wish for the life insurance premium payments to match my Social Security Benefit Deposit ☐ Yes ☐ No

If "Yes" please select date of Social Security Benefit Payment: ☐ 1st of month ☐ 3rd of month ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

BANK INFORMATION

Name of Bank: _____

Bank address: _____

COMPLETE THE FOLLOWING and SUBMIT A VOIDED CHECK

BANK INDEMNIFICATION AGREEMENT

To the bank addressed above: So that you may comply with your depositor's request the Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions taken pursuant to your agreement to honor any check or electronic fund transfer (EFT) executed by this Company for the purpose of payment of insurance premiums.
2. That in the event any such check or EFT is dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss.
3. To defend at our own cost and expense any such action brought against you by any depositor or other person because of your actions pursuant to this agreement.
4. To refund you any amount erroneously paid to this Company on such check or EFT if claim is made within one month of the date of the check.

Account Type: ☐ **Checking** ☐ **Savings**

Bank Routing Number: | | | | | | | | | |

Bank Account Number: | | | | | | | | | | | | | | | | |

FAMILY BENEFIT
LIFE INSURANCE CO.
ADMINISTRATIVE OFFICE: PO BOX 5205 • FRANKFORT, KY 40602-5205
Phone: (866) 440-1357 • Fax: (502) 227-7205

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the agent, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ❑ YES ❑ NO.
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ❑YES ❑NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because: _____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant’s Printed Name	Applicant’s Signature	Date
Agent’s Printed Name	Agent’s Signature	Date

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not have the notice read aloud.)