ELCO MUTUAL
LIFE & ANNUITY

Silver Eagle Final Expense Application Instructions

General Information

Application for individual life insurance form number: ICC19-FEAPP19. Print all information in black ink. Minimum face amount of $2,500 required for both the level and modified benefit. The maximum face amount allowed on the level benefit is $35,000 and $25,000 on the modified benefit. A single pay life rider is also available on the level benefit, but the combined face amount of the two cannot exceed the $35,000 amount. Issue ages are 50-85 on the level benefit and 50-80 on the modified benefit.

Application Information

1. Complete all fields in the “Proposed Insured” section.
2. Complete the “Owner” section if the owner and proposed insured are different.
3. Complete the “Payor” section if the owner and payor are different.
4. The “Underwriting” section consists of two parts. If any question in “Part A” is answered “Yes” the applicant is not eligible for coverage. If a question in “Part B” is answered “Yes” the applicant may be eligible for the modified benefit.
5. If all questions are answered no, the applicant may be eligible for the level benefit. If no questions are answered “Yes” in “Part A”, continue with the point-of-sale interview with ELCO Mutual’s underwriters whose information can be found below.
6. After receiving an underwriting decision, complete the plan information section by selecting the plan, payment mode, dividend option, and modal premium.
7. Complete the beneficiary designation section. If the Irrevocable Trust is used, please use the name of the trust on the form.
8. Complete the replacement section and fill out the replacement form if applicable.
9. Complete the “Agreements and Acknowledgments” section and have both you and the applicant sign all the appropriate fields to ensure a seamless issuing process.
10. As a mutual company, we are owned by the policyowners. We want all proxy information completed and signed. Normally, this section is answered yes.

MRS Underwriting Information

Hours: Monday-Friday 8:00 a.m. - 9:00 p.m. CST and Saturday 8:00 a.m. - 3:00 p.m. CST
Phone Number: (844) 442-9994

ELCO MUTUAL
LIFE & ANNUITY

916 Sherwood Drive
Lake Bluff, IL 60044
847-295-6000
800-321-ELCO

Application for Individual Life Insurance

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex ☐ Male ☐ Female	Height	Weight	Social Security No./EIN

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a legal resident of the United States? ☐ **Yes** ☐ **No** **(if "No", you are not eligible for coverage)**	**In the last 12 months**, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No**

OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured

Policyowner Address (Street, City, State, Zip)	Phone No.	Social Security No.

Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country

PAYOR (Complete only if Payor is different from Owner)

Name of Payor (First, Middle Initial, Last)

Payor Address (Street, City, State, Zip)	Phone No.	Social Security No./EIN

Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country

Relationship to Proposed Insured	Relationship to Owner (if different from Proposed Insured)

UNDERWRITING

Part A IF THE APPLICANT ANSWERS "YES" TO ANY QUESTION IN PART A, HE/SHE IS NOT ELIGIBLE FOR COVERAGE. IF ALL QUESTIONS ARE ANSWERED "NO" IN PART A, HE/SHE WILL BE CONSIDERED FOR THE LEVEL BENEFIT.

1. Do you: **(a)** Require human assistance or supervision with taking medications, eating, dressing, toileting, transferring from bed to chair, walking, or bathing? ..... **(b)** Require oxygen to assist in breathing or have you been diagnosed by a medical professional with paralysis of two or more extremities?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
2. Have you ever been advised by a medical professional that you have a terminal illness or end stage disease of any type expected to result in death within the next 24 months?.....	☐ **Yes** ☐ **No**
3. Are you currently hospitalized, bedridden, receiving hospice or home health care, confined to a nursing home? Have you been hospitalized more than once in the last 12 months?	☐ **Yes** ☐ **No**
4. Have you ever: **(a)** Been diagnosed or treated 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)?..... **(b)** Been diagnosed or treated by a medical professional, or taken medication for organic brain syndrome, Alzheimer's disease, dementia, memory loss or impairment, Lou Gehrig's disease, amyotrophic lateral sclerosis (ALS), mental incapacity, Huntington's disease or other neuromuscular or brain disease (including cerebral palsy, multiple sclerosis, muscular dystrophy, cystic fibrosis)?..... **(c)** Been diagnosed or treated by a medical professional, or taken medication for kidney or liver failure, cirrhosis, congestive heart failure, cardiomyopathy, or chronic kidney disease including dialysis? ..... **(d)** Been diagnosed by a medical professional for more than one occurrence of any cancer or any metastasis in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated or advised to have treatment by a member of the medical profession for cancer or recurrence of cancer? ..... **(e)** Had, or been advised by a medical professional to have, an internal organ transplant?.....	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
5. **In the past 24 months**, have you been medically diagnosed as having, been treated or been advised by a medical professional to have treatment for or been hospitalized for: **(a)** Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease or Parkinson's disease?..... **(b)** Insulin shock, diabetic coma, amputation due to diabetes? ..... **(c)** Abuse or dependence on alcohol or drugs (including prescription drugs) or attempted suicide?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
6. Have you been medically diagnosed as having, been treated or been advised by a medical professional to have treatment for or been hospitalized for TWO or MORE of the following conditions: stroke or TIA, heart disease or heart attack, heart valve replacement, insulin dependent diabetes?.....	☐ **Yes** ☐ **No**

Part B IF THE APPLICANT ANSWERS "YES" TO ANY QUESTION IN PART B, HE/SHE WILL BE CONSIDERED FOR THE GRADED BENEFIT.

7. **In the past 24 months**, have you been medically diagnosed as having, been treated or been advised by a medical professional to have treatment for or been hospitalized for: **(a)** Uncontrolled high blood pressure, pulmonary hypertension, chest pain/angina, heart attack, irregular heart rhythm, heart surgery (including bypass, angioplasty or stent placement), stroke, transient ischemic attack (TIA), abdominal aortic aneurysm or had a pacemaker or defibrillator implanted? ..... **(b)** Any respiratory disease including chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis or pulmonary fibrosis or have you required oxygen equipment to assist in breathing?..... **(c)** Chronic pancreatitis, chronic hepatitis or any blood disorders? ..... **(d)** Parkinson's disease or grand mal epilepsy with 6 or more seizures per year?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
8. **Within the past 3 years**, have you: **(a)** Been medically diagnosed, treated or advised to have treatment for or been hospitalized for schizophrenia, schizoaffective disorder, bipolar disorder, alcohol or drug abuse?..... **(b)** Been convicted of a felony or are you awaiting trial for a felony or been convicted of reckless driving, operating a vehicle while impaired or under the influence of drugs or alcohol (DWI/DUI)?..... **(c)** Been declined or postponed for life or health insurance?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
9. Have you in the past 12 months been advised by a medical professional to have surgery, hospital confinement or nursing facility confinement and have not done so?.....	☐ **Yes** ☐ **No**

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product. Underwriting will take the Proposed Insured's height and weight into consideration.

UNDERWRITING-OPTIONAL COMMENTS (Not Required) – Provide any additional information available

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

Remarks: _____

_____

_____

_____

PLAN INFORMATION

Plan:
☐ Level Benefit Product ☐ Graded Benefit Product

Amount Applied For $_____

Rider: (Only if selecting Level Benefit Product)
☐ Single Premium Life

Payment Mode:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Electronic Funds Transfer)

Automatic Premium Loan? ☐ Yes ☐ No

First Draft Date:_____/_____/_____ Modal Premium $_____ Amount Paid with Application $_____

Dividend option: ☐ Reduce Premium ☐ Purchase Additions ☐ Leave on Deposit ☐ Cash

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary	Relationship to Insured	Date of Birth
Contingent Beneficiary	**Relationship to Insured**	**Date of Birth**

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contract with the company or any other company? ..... ☐ **Yes** ☐ **No**

2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? ..... ☐ **Yes** ☐ **No**

If "Yes" to question #1 or #2, please give details below. If more space is needed, list on a separate sheet of paper.

Company	Proposed Insured	Face Amount	To Be Replaced or Converted?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned agree(s) that all answers in this application are true and complete to the best of my knowledge and belief. ELCO Mutual Life and Annuity (ELCO) will rely on these answers to determine insurability. Incorrect or misleading answers may void this application and any issued policy effective the issue date.

2. The undersigned acknowledge(s) that ELCO may require medical records, an underwriting assessment, a medical examination, or other information.

3. The undersigned agree(s) that ELCO will not issue a policy as a result of this application unless the Proposed Insured completes all medical examinations and tests required by ELCO and any additional information requested for underwriting. The Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for. ELCO will not issue a policy as a result of this application if the Proposed Insured or the Applicant (if other than the Proposed Insured) has accepted an offer by ELCO for coverage other than as applied for at a later date, according to ELCO's underwriting standards then in force.

4. The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, the undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective. Any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until ELCO issues a policy and receives payment of the full initial premium according to the mode of payment specified in the application.

5. A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).

6. The undersigned acknowledge(s) that no producer can waive or change any receipt or policy provision; or agree to issue a policy.

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.

I have received the MIB, Inc. Pre-Notice, the Notice of Information Practices and a Life Insurance Buyer's Guide before completing this application.

If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

I approve the answers to the questions in this application as recorded.

I have read and understand the Authorization to Receive Information form and Disclosure Information to MIB, Inc. and the Agreement Section.

Signed at: _____ _____
City State

_____ Date: _____
Signature of Proposed Insured

_____ Date: _____
Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Producer Statement:

By signing below, I/we, the Agent(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

Do you, the Agent(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? ..... ☐ **Yes** ☐ **No**

Has the Proposed Insured informed you, the Agent(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company? ..... ☐ **Yes** ☐ **No**

(If either question is answered "Yes", fulfill all state and company requirements.)

Are you related to the Proposed Insured or Owner? ..... ☐ **Yes** ☐ **No**

If "Yes", state relationship: _____

How long have you known the Proposed Insured? _____

How long have you known the Proposed Owner? _____

_____	_____	_____	_____
Signature of Agent #1	Producer Email	Producer Number	Date
_____	_____	_____	_____
Signature of Agent #2	Producer Email	Producer Number	Date
_____	_____	_____	
Print Agent #1 Name	Print Agent #2 Name	Agency Name	

MIB Pre Notice

Information regarding your insurability will be treated as confidential. ELCO Mutual Life & Annuity or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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. 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, MA 02184-8734

ELCO Mutual Life & Annuity, or its reinsurers, may also release information in its file to other 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.

ELCO Mutual Life and Annuity

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Life Insurance Application
This Authorization Complies with the HIPAA Privacy Rule.

I understand ELCO Mutual Life and Annuity (ELCO), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for insurance. I authorize any Medical Providers, as described below, to disclose or release Protected Health Information, as described below, to ELCO Mutual Life and Annuity, 916 Sherwood Drive, Lake Bluff, Illinois 60044-2285 or its authorized representative.

• Medical Providers: All physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities and all other providers of medical or dental services who have provided treatment or other health care services to me or on my behalf.

• Protected Health Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected health information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

In addition, I authorize the Veterans Administration, the MIB, Inc., my employer, consumer reporting agency, insurance company or other organization who possesses information, records or knowledge of me including information about drugs, alcoholism or mental illness, to furnish such information to ELCO, its reinsurers and their authorized representative upon presenting this authorization.

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 any Medical Provider to release and disclose my entire medical record without restriction.

The purpose of the release of the above information is for ELCO to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such insurance coverage, and/or to resolve any issues of incomplete, incorrect or misrepresented information on the application which may arise during the processing of the application.

I authorize ELCO Mutual Life and Annuity or its reinsurers to make a brief report of my Protected Health Information to MIB, Inc. ELCO or its reinsurers may make a brief report regarding me or my children to other insurance companies to whom I have applied or may apply.

This authorization will remain in effect from the date signed below for a period of 24 months, and a copy of this authorization is as valid as the original. I understand that this authorization may be revoked at any time by sending written notice of such to ELCO at the address above. The right to revoke this authorization is limited to the extent that ELCO has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under the policy for which I have applied or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or as allowed by law.

I understand that my Medical Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization, ELCO may not issue the insurance coverage for which I am applying or if coverage has been issued may not be able to make any benefit payments. I understand that any Personal Representative or I will receive a copy of this authorization upon request.

I authorize ELCO Mutual Life and Annuity to obtain an investigative consumer report on me, if required.

☐ I elect to be interviewed if any investigative consumer report is prepared in connection with this application.

_____

Signature of Proposed Insured

_____ _____

Printed Name *Date*

In Florida, the company is known as **ELCO Mutual Life and Annuity Company**.

AUTH14

ELCO MUTUAL
LIFE & ANNUITY

Pre-Authorized Check / Electronic Funds Transfer Program

916 Sherwood Dr
Lake Bluff, IL 60044
800-321-3526

What is it?

- A safe, convenient and money-saving way to pay your monthly or initial insurance premium(s).
- Automatically deducts payments from your checking or savings account.

Why should you enroll?

- No more envelopes, stamps or checks to write.
- No missed payments.

What date will monthly deduction be made?

- Your deduction date will be the same day of the month as your policy's effective date unless preferred draft date is indicated on the next page. (If your policy's effective date is the 29th, 30th or 31st your payment will draft on the 28th.)
- Premiums will be processed during the month the premium is due.

How do you start?

- Complete the form on page 2 and attach a voided check, **NOT** a deposit slip.

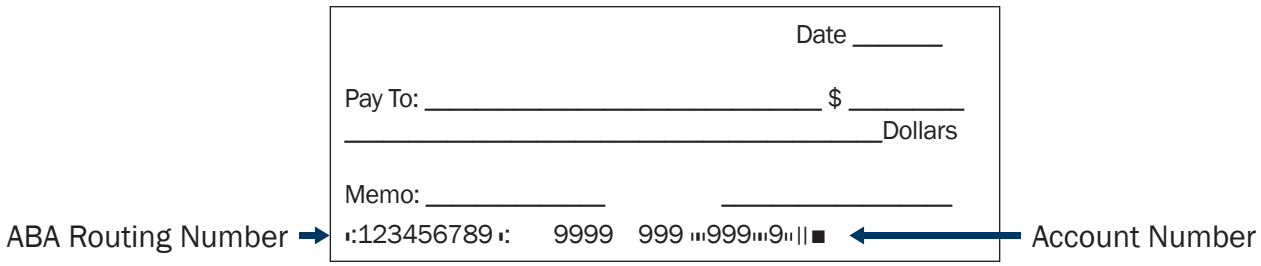
Other questions?

- If you have any questions phone us or contact us in writing at the above address.
- Your agent or banker may be able to help you fill out the information on the form.
- If the monthly amount changes you will receive advance notice from us.

Subject to the following conditions:

1. The privilege of paying premiums under this plan may be revoked by us if any draft or other instrument is not honored upon presentation.
2. This plan shall not be construed as a modification of any policy provisions except that during the continuance of this plan we shall not be required to give notice of any premium becoming due on any policy paid by this authorization. You will receive advance notice if the monthly amount changes.
3. Monthly drafts or other instruments will be drawn for deposit on or before each due date.
4. No dividend may be applied against a due premium, and dividends currently under that option will be left to accumulate at interest with us until otherwise notified.
5. All policy payments must be monthly or initial.
6. The payment of premiums under this plan may be discontinued by us or you upon thirty (30) days written notice.

How to read your check.



Sign Up Today For Ease Tomorrow

INDEMNIFICATION AGREEMENT

To: The bank named below. So that you may comply with your depositor's request we agree:

1. To indemnify you and hold you harmless from any loss hereunder 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 or not genuine, purporting to be received and executed by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, draft or order hereunder shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance or benefits.
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.

Authorized by the Executive Committee of ELCO Mutual Life & Annuity.

AUTHORIZATION FOR AUTOMATIC DEDUCTIONS

☐ **NEW** ☐ **Change Existing Information**

I/we hereby authorize ELCO MUTUAL LIFE and ANNUITY to initiate monthly or a single deduction(s) from my/our bank account for the ELCO MUTUAL LIFE and ANNUITY insurance policy(ies) listed and any renewals thereof.

☐ **Checking Account** (A VOIDED check or check copy is required) ☐ **Savings Account** (Please include a copy of a bank document showing account and ABA routing number)

Your Name(s): _____ Your Phone: _____

Bank Name: _____ List existing policies for monthly deductions (If applicable):

Bank Address: _____ 1. _____

_____ 2. _____

ABA Routing Number: _____ 3. _____

Account Number: _____ Preferred Draft Date: _____

Attach a VOIDED check or check copy here.

_____ _____

Signature of Bank Account Owner Date

_____ _____

Signature of Joint Bank Account Owner Date

ELCO MUTUAL
LIFE & ANNUITY

Irrevocable Funeral Trust Uses and Instructions

General Information

ELCO Mutual offers an irrevocable funeral trust to its policyowners. If you have any questions regarding when or if the trust agreement form should be used, please contact ELCO Mutual's home office by phone at (888) 240-3351.

When to Use the Irrevocable Funeral Trust

The irrevocable funeral trust should be used for:

1. **Estate Planning**
2. **Prearrangement for Funeral Expenses**
3. **Asset Positioning for Government Benefits* (please refer to state specific regulations for use)**

Example

Please be sure to complete all the following fields. The beneficiary will be the irrevocable funeral trust. The name of the trust will be the name of the grantor plus irrevocable funeral trust. If the insured and owner are different, please make sure to indicate so the form.

IRREVOCABLE FUNERAL TRUST AGREEMENT

Grantor/Owner: John Smith Date of Agreement: 7/1/19

Beneficiary: " John Smith Irrevocable Funeral Trust", Richard P. Leach, Trustee
(Name of Grantor/Owner)

Secondary Beneficiary: Jane Doe
(or "Estate" if no other beneficiary is named)

Tertiary Beneficiary: Jack Smith

Life Insurance Policy:

Life Insurance Company: ELCO Mutual Life and Annuity

Insured: John Smith

Life Insurance/Annuity Policy #: L123456

Initial Amount of Insurance: $10,000

When signing, the agent will sign as the witness and the owner will sign as grantor. Once received, the trustee will sign at ELCO Mutual.

IN WITNESS WHEREOF, the parties thereto have set their hand and seal on the date written above.

WITNESS: *Valued Agent* GRANTOR: *Jack Smith*

TRUSTEE: *Richard Leach*

PNITA ED.6/19

***Not associated or endorsed by any government program or agency. Each state has different requirements. It is the responsibility of the agent to make sure the policy and trust meet the requirements of the state.**

IRREVOCABLE FUNERAL TRUST AGREEMENT

Grantor/Owner:_____Date of Agreement:_____

Beneficiary: "_____ Irrevocable Funeral Trust", Richard P. Leach C.S, Trustee
(Name of Grantor/Owner)

Secondary Beneficiary: _____
(or "Estate" if no other beneficiary is named)

Tertiary Beneficiary:_____

Life Insurance Policy:

Life Insurance Company: ELCO Mutual Life and Annuity

Insured: _____

Life Insurance/Annuity Policy #: _____

Initial Amount of Insurance: _____

THIS IRREVOCABLE FUNERAL TRUST AGREEMENT is entered upon the following terms and conditions:

1. **TRUST ESTATE**: The Grantor hereby establishes this Trust and names Richard P. Leach, Corporate Secretary, as Trustee of the Trust. The Grantor has named the Trust beneficiary of a certain life insurance or annuity policy on the life of the insured as shown above. The policy and the benefits payable under it are hereafter referred to as the "Trust Estate". The Trust Estate shall be held and distributed in accordance with the provisions and for the purposes stated herein. The Grantor and the life insurance company shall have custody of the copies of the policy and this Trust.

2. **TRUST AS BENEFICIARY:** The Grantor shall be the owner of the policy and the Trust shall be the beneficiary of the policy proceeds upon the death of the Grantor. Neither the Trust nor the Trustee shall have the responsibility to pay the premiums for the policy. The Grantor shall pay all premiums due for the policy. Should the policy lapse or otherwise terminate, this Trust shall also terminate concurrently.

3. **DISTRIBUTION UPON DEATH:** Upon the death of the Insured, the surviving spouse, estate of the insured, or funeral establishment shall notify the life insurance company indicated above and provide the necessary proof of loss to Trustee. The Trustee shall then claim the proceeds payable under the policy. Grantor directs and requires that Trustee shall distribute said proceeds to pay for the purchase or rental of personal property or professional services for the final disposition of the Insured's body. However, in no event shall Trustee be required to pay any amount in excess of said proceeds. Any proceeds in excess of funeral expenses described herein shall be paid by the Trustee to the secondary beneficiary or the estate of the Insured if no secondary beneficiary is named.

4. **POWERS OF TRUSTEE:** The Trustee is hereby authorized to and shall perform all acts necessary in fulfilling the purpose and intent of this Agreement. The Trustee shall not be liable for any mistake or error of judgment in the administration of the trust, including but not limited to Distributions made pursuant to paragraph 3, except for willful misconduct. The Grantor hereby authorizes ELCO Mutual Life and Annuity to appoint any person or concern as a Successor Trustee, to fill any vacancy created by death, resignation or inability to act of the Trustee. No bond shall be required of the Trustee or of any Successor Trustee who shall serve hereunder. Any Successor Trustee shall have and may exercise all the rights, powers, duties and discretions conferred or imposed on the original Trustee.

5. **SPENDTHRIFT PROVISIONS:** No title in the Trust Estate, nor in the income therefrom, shall vest in the heirs of the Grantor, and neither the principal nor the income of this trust shall be liable to be reached in any manner by the creditors of the Grantor except as stated herein, or by the creditors of the heirs of the Grantor. Further, the Grantor and the heirs of the Grantor shall not have any power to alienate, encumber, anticipate or dispose of any interest in the Trust Estate, nor the income therefrom, except for the purpose of arranging for payment of the purchase or rental of personal property or professional services for the final disposition of the Insured's body.

6. **IRREVOCABILITY AND ASSIGNMENT OF RIGHTS UNDER POLICY:** This Agreement and the trust herein created are irrevocable. The Grantor shall have no power to alter, amend or modify this Agreement in any way. Grantor further irrevocably assigns to the Trustee all rights under the policy to surrender the policy for cash, obtain a loan against the policy, elect to exercise any of the dividend options in the policy, reassign ownership of the policy or change the beneficiary of the policy, except that the secondary beneficiary may be changed in the manner set out in the life insurance policy for change of beneficiary.

IN WITNESS WHEREOF, the parties thereto have set their hand and seal on the date written above.

WITNESS: _____ GRANTOR: _____

TRUSTEE: _____

ELCO MUTUAL
LIFE & ANNUITY

916 Sherwood Drive
Lake Bluff, Illinois 60044-2285
888-872-7954

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 the 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 in 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 (including the name of the insurer, the contract or policy number, if available, the insured or annuitant name) and whether each policy or contract will be replaced or used as a source to finance the new ELCO policy:

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

ELCO MUTUAL
LIFE & ANNUITY

916 Sherwood Drive
Lake Bluff, Illinois 60044-2285
888-872-7954

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 sale 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 Signature and Printed Name	Date	Telephone Number

Agent's Signature and Printed Name	Date	

I do not want this notice read aloud to me. _____

(Applicant must initial only if they do not want notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older – are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

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INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. (Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.)

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable “grand fathered” treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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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 the 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 in 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 (including the name of the insurer, the contract or policy number, if available, the insured or annuitant name) and whether each policy or contract will be replaced or used as a source to finance the new ELCO policy:

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

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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 sale 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 Signature and Printed Name	Date	Telephone Number

Agent's Signature and Printed Name	Date	

I do not want this notice read aloud to me. _____

(Applicant must initial only if they do not want notice read aloud.)

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PREMIUMS:

Are they affordable?

Could they change?

You're older – are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

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Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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800-321-ELCO

FACT SHEET

For I. R. S. Section 1035 Exchange

To be completed by agent and submitted with each transfer/exchange form

Proposed Annuitant: _____

Proposed Owner: _____

Existing Company: _____

Existing Policy #: _____

Existing Policy Type: ❒ Life Insurance ❒ Annuity

If annuity, type: ❒ Deferred ❒ Variable

Approximate amount to be transferred: $_____

Surrender charge (if any): $_____

Proposed ELCO plan: ❒ Deferred Annuity ❒ Immediate Annuity

Indicate rationale for this exchange:

_____

_____

_____

_____

_____ _____

Printed Name of Writing Agent *Agent Code Number*

_____ _____

Signature of Writing Agent *Date*

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800-321-ELCO

LETTER OF UNDERSTANDING

Re: Application for life insurance policy or annuity contract of

_____(the "Trust"), dated_____.
Name of Trust *Date of Trust*

To ELCO Mutual Life & Annuity:

In connection with the application for the life insurance policy or annuity contract of the Trust, we, _____, and_____ hereby acknowledge that
Name of Grantor *Name of Acting Trustee*
ELCO Mutual Life & Annuity shall have no obligation under the Trust of the policy/contract for which application is made, by operation of law or otherwise, to administer the Trust, including, without limitation, to distribute any insurance proceeds which may become payable to the beneficiaries under the operative Trust documents thereupon. Additionally, we hereby acknowledge that this letter shall not be made a part of the policy for which application is made.

We may direct any questions regarding this form to ELCO Mutual Life & Annuity at their home office at 1-800-321-3526.

Sincerely,

Name of Grantor (*Print Name*): _____
Signature:_____Date: _____

Name of Acting Trustee (*Print Name*): _____

Signature:_____Date: _____

(Only one of the two signatures above are required)

Grantor Contact Information

Address: _____

Telephone: _____Fax: _____E-Mail: _____

Acting Trustee Contact Information

Address: _____

Telephone: _____Fax: _____E-Mail: _____

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LIFE & ANNUITY

916 Sherwood Drive
Lake Bluff, Illinois 60044-2285
847-295-6000
800-321-ELCO

RECEIPT

This receipt is given to _____ **whose address is**
(Name of Proposed Applicant)

_____
Street Address City State Zip Code

In conjunction with an application for a life insurance policy, I have received the following item(s) from the above named proposed applicant to forward to ELCO Mutual Life and Annuity. Said item(s) is/are to be redeemed, liquidated or transferred for the benefit of the above named proposed applicant.

Item Description	Name of Issuing Institution	Check/Certificate Number

Additional Comments: _____

Printed Name of Agent: _____
Signature of Agent: _____
Agent Telephone Number: _____
Agent Address: _____