HOME OFFICE:
7633 East 63rd Place, Suite 230
Tulsa, OK 74133
(918) 249-2438

ADMINISTRATIVE OFFICE
PO BOX 5205
Frankfort, KY 40602-5205
Phone: (866) 440-1357
ax: (502) 875-7084

FAMILY BENEFIT LIFE INSURANCE CO.

MEDICAL AND CONSUMER REPORTS AUTHORIZATION

Name of Proposed Insured/Patient	Date of Birth Month | Day | Year	Social Security Number	Policy Number (if known)

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE:

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, medical care facility, health care provider, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsurance company, insurance support organization (such as MIB, LLC.), consumer reporting agency, state Motor Vehicle Departments, or public records holder, or other provider that has provided treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose information about me, including but not limited to, my entire medical record, medication history, or any other protected health or consumer information to Family Benefit Life Insurance Company ("the Company"), its agents, employees, representatives, reinsurers, or any MIB-authorized third-party administrator performing services on the Company's behalf.

I understand the Company, its reinsurers, or any MIB-Authorized third-party administrator performing services on the Company's behalf may re-disclose any information pursuant to this authorization, including the reporting of protected health information or personally identifiable information to MIB, LLC.

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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 my entire medical record without restriction.

This information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I agree that a copy of this authorization, or my recorded voice or electronic authorization, is as valid as the original. This authorization shall remain in force for 36 months (or a shorter time period if required by applicable state law) following the date of my signature below, regardless of my condition and whether living or deceased. 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, 7633 East 63rd Place, Suite 230, Tulsa, OK 74133 Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already 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 re-disclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, the Company will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their 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 understand that my authorized representative or I am entitled to a copy of this signed authorization.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient
(For death claims, please attach copy of appointment of executor of estate.)

www.familybenefitlife.com

FAMILY BENEFIT LIFE INSURANCE CO.

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7633 East 63rd Place, Suite 230
Tulsa, OK 74133
918-249-2438 • 918-249-2478 fax

Administrative Office:
PO Box 5205
Frankfort, KY 40602-5205
866-440-1357 • 502-875-7084 fax

Life Application Part 1

Application for Life Insurance ❑ Term Life ❑ Whole Life

1. **Name of Proposed Insured:**
   _____
   First Middle Last
2. **Age**:_____ **Marital Status**:_____
3. **Sex:** ❑ Male ❑ Female **U.S. Citizen:** ❑ Yes ❑ No
4. **Date of Birth**: Month_____ Day_____ Year_____
5. **State of Birth**:_____
6. **Social Security #:**_____
7. **Residence Address:**_____
   _____
8. **Telephone Number:** Home_____
   Business_____
9. **Employer:** Name_____
   Address_____
   _____
10. **Occupation:** Title_____
    Industry/Duties_____
11. **Plan Applied for:**
    ❑ Term: ❑ 10yr ❑ 15yr ❑ 20yr ❑ 30yr
    ❑ Whole Life
    ❑ Value Builder: Units _____
12. **Amount Applied for:** $_____
    Premium Class (if applicable):
    ❑ Preferred Non-Tobacco
    ❑ Standard Non-Tobacco
    ❑ Preferred Tobacco
    ❑ Standard Tobacco
13. **Riders**: (if applicable)
    ❑ Waiver of Monthly Premium Rider
    ❑ Terminal Illness Accelerated Benefit Rider
    ❑ Accidental Death Benefit Rider
    ❑ Other: _____
14. **Owner:** (if other than Proposed Insured)
    ❑ Corporation
    ❑ Partnership
    ❑ Trust
    ❑ Other
    Owner Name_____
    Address_____
    _____
    Soc. Sec. or TIN_____
    Relationship_____
15. **Special Information for Premium Notices:**
    Name_____
    Billing Address_____
    _____
16. **Beneficiaries:**
    Primary_____ Relationship_____
    Date of Birth_____ SS#_____
    Address_____
    Contingent_____ Relationship_____
    Date of Birth_____ SS#_____
    Address_____
17. **Payment Method:** ❒ Annual ❒ Semi-Annual ❒ Quarterly ❒ Monthly
    ❑ Single Pay ❑ 10 Pay
    Mode of Premium: $_____
    Premium Collected: $_____ or ❒ None – Draft First Premium
    If Monthly, Draft Date _____ (1st - 28th) or ❒ 2nd Wed, ❒ 3rd Wed, ❒ 4th Wed.
    Requested Effective Month _____ Yr _____
18. **Automatic Premium Loan:** (if applicable) ❑ Yes ❑ No
19. **Replacement of Existing Insurance:**
    ❑ Yes Will insurance, including annuities, in any company
    ❑ No be discontinued or changed if the insurance applied for is issued?
20. **Other Insurance now in force:**
    Total Life Insurance All Companies: $_____
    Company / Amount / Issue Yr. Replace
    _____ ❑ Yes ❑ No
    _____ ❑ Yes ❑ No
21. **Pending Insurance:** ❑ Yes ❑ No
    Is any application for life insurance on the Proposed Insured pending in any other Company? Explain "Yes" in Remarks Section on next page, including name of company, amount applied for and type of coverage.
22. **Prior Insurance:** ❑ Yes ❑ No
    Has any other company declined to issue, reinstate or renew, rated, modified, postponed or cancelled any life insurance on the Proposed Insured?
23. **Foreign Travel:** ❑ Yes ❑ No
    Does Proposed Insured intend to travel outside of the U.S. or Canada within the next two years, except for purely vacation travel?
    If "Yes" complete Foreign Questionnaire.
24. **Military:** ❑ Yes ❑ No
    Is the Proposed Insured a member of the U.S. Armed Forces, Reserves or National Guard?
    If "Yes", complete Military Questionnaire.
25. **Sports / Avocations:** ❑ Yes ❑ No
    Within the past two years has the Proposed Insured participated in or intends within the next two years participating in: skydiving, hang gliding, ballooning, ultralights, skin or scuba diving, mountain or rock climbing, auto, motorcycle, snowmobile or motorboat racing?
    If "Yes" complete Sports / Avocation Questionnaire.
26. **Aviation:** ❑ Yes ❑ No
    Within the past two years has the Proposed Insured made or intends within the next two years making flights as a pilot, student pilot or crew member?
    If "Yes", complete Aviation Questionnaire.
27. **Driving:** Proposed Insured's drivers license:
    No. _____ State:_____
    Within the past 5 years has the Proposed Insured been convicted of or plead guilty to:
    ❑ Yes ❑ No Moving Violations:
    Date(s)/Type_____
    _____
    ❑ Yes ❑ No Driving under the Influence of alcohol or drugs:
    Date(s) _____
28. Within the past 5 years, has the Proposed Insured been convicted of a felony? ❑ Yes ❑ No
    If "Yes" give details including County/State of Conviction:
    _____
    _____

Life Application Part 2

COMPLETE FULLY. Answer each question and provide details to all "Yes" answered questions.

1. Proposed Insured: Height _____ Weight _____ ❑ Gain ❑ Loss in past year? _____ lbs.
To the best of your knowledge and belief:

2. Has the proposed insured used tobacco products or nicotine in any form within the past 24 months (60 months for Preferred Classes)? *(This includes nicotine gum and patches.)* ❑ Yes ❑ No

3. **Has the proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder for… (If "Yes", circle disorder & give details below.)**

- a. Heart, blood vessels, chest pain, high blood pressure? ❑ Yes ❑ No
- b. Eyes, ears, nose or throat? ❑ Yes ❑ No
- c. Brain, mental or emotional disorder, paralysis or stroke? ❑ Yes ❑ No
- d. Respiratory system, shortness of breath, asthma, emphysema or allergy? ❑ Yes ❑ No
- e. Cancer, tumor or cyst? ❑ Yes ❑ No
- f. Stomach, intestines, colon, liver, pancreas or gall bladder? ❑ Yes ❑ No
- g. Diabetes, thyroid, pituitary or other gland? ❑ Yes ❑ No
- h. Breasts, prostate, male or female reproductive organs? ❑ Yes ❑ No
- i. Kidneys, bladder or urinary system, sugar, albumin or blood in the urine? ❑ Yes ❑ No
- j. Nervous system, seizures, convulsions, epilepsy, dizziness or fainting spells? ❑ Yes ❑ No
- k. Depression, anxiety, psychiatric treatment or counseling? ❑ Yes ❑ No
- l. Any disease of the lymph nodes, night sweats, fatigue or unexplained fever? ❑ Yes ❑ No
- m. Received medical treatment or counseling for use of alcohol or alcoholism? ❑ Yes ❑ No
- n. Received medical treatment or counseling for use of narcotics or non-prescribed drug use, other than those prescribed by a physician? ❑ Yes ❑ No

4. In the past 5 years, has the proposed insured... (If "Yes", circle disorder & give details below.)

- a. Been in a hospital, clinic, sanatorium, or other institution for examination, diagnosis, observation, operation or treatment? ❑ Yes ❑ No
- b. Had an x-ray, electrocardiogram, blood study, cardiovascular test or other laboratory test? ❑ Yes ❑ No
- c. Consulted or been treated or examined by a medical professional for any medical concerns not previously mentioned in this application, or attempted suicide? ❑ Yes ❑ No
- d. 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? ❑ Yes ❑ No

5. Does the proposed insure have a parent or sibling diagnosed or treated by a member of the of the medical profession for diabetes, cancer, heart or cardiovascular disease, attempted suicide or mental illness? (If Yes, give details in 6. below) ❑ Yes ❑ No

6. Has the proposed insured ever been diagnosed or treated by a member of the medical profession as having: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV (Human Immunodeficiency Virus) virus? ❑ Yes ❑ No

7. **Details** of all "Yes" answers to **Part 2** questions 1-6, attach additional sheet if necessary (must be signed)

Question No. Specify details and nature of condition; dates of treatment; complete names and address of hospitals and physicians.

8. Family History:

	Age	Health	Age at Death	Cause of Death
Father	___	_____	_____	_____
Mother	___	_____	_____	_____
Siblings	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____

Details:

Remarks: (for all questions on Part 1 & Part 2, indicate which question and give details)

Home Office Endorsements:

**Note: All of these products may not be available in the applicant's state. Please check with the Home Office if you are unsure if the product in question is approved. See your Agent's Guide for face amount limitations, premiums and other product information.*

AGENT INSTRUCTIONS:
As the writing Agent you and you alone are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed fully and must be legible.

DO:
- Print the application in black or blue ink.
- Obtain all necessary signatures.
- Complete and sign the Agent's Report.
- Have the applicant initial any changes.
- Change any answer by drawing a line through the incorrect answer and insert the correct information.
- Complete and leave Conditional Receipt with the applicant / owner.
- All checks or money orders must be payable to *Family Benefit Life Insurance Company.*

DO NOT:
- Accept any monies or leave the Conditional Receipt on application totaling $500,000 or more.
- Accept any monies on applicants over age 70.
- Use a pencil or correction fluid.

Failure to follow the instructions and / or to complete the application fully will result in a delay of processing or outright rejecting of the application. If you have any questions, you should contact your Managing Agent, Agency Services or the Home Office.

AGENT'S REPORT – To be completed by writing Agent (explain details in remarks section)

1. Are you related any of the proposed insureds? If yes, state relationship:_____ ❑ Yes ❑ No
2. Did you witness all proposed insureds when completing this application? If not, why? ❑ Yes ❑ No
3. Did you verbally ask the proposed insured(s) all medical questions? ❑ Yes ❑ No
4. Did you witness the proposed insured(s) signing the application? ❑ Yes ❑ No
5. Did you receive any money with the application? ❑ Yes ❑ No
6. Were only Company materials approved for use in the state where the application was taken used? ❑ Yes ❑ No
7. Did you obtain all required disclosures? ❑ Yes ❑ No
8. Did you leave all required disclosures with the applicant(s)? ❑ Yes ❑ No
9. Did you quote any special class extra premium for this policy? If Yes, why, how much, and for what Table Class? ❑ Yes ❑ No
10. How well do you know the applicant(s)? _____
11. If insured is age 0 through 17, complete the following:
    a. If less than 1 year of age, what was the birth weight: _____ lbs. _____oz. Did you see the Child? ❑ Yes ❑ No
    b. Number of siblings: _____ c. Do they all have, or are they all applying for like amounts of insurance? ❑ Yes ❑ No
12. Financial Information:
    a. Annual Income of Proposed Insured: _____ b. Estimated Net Worth of Proposed Insured: _____
13. If required, have you ordered or obtained: ❑ Exam ❑ Blood Profile ❑ Urine Specimen ❑ Other_____
14. Provide name of paramedical company or examiner: _____
15. Your calculation of annual premium:

Life Insurance Base Plan	$_____
Waiver of Premium	$_____
Accidental Death Benefit	$_____
Other Benefits or Riders	
_____	$_____
Annual Policy Fee	$_____
Total Annual Premium:	$_____

Amount of Monies Submitted: $_____

14. Answer for all Business Needs Coverage and/or Keyman
    a. Purpose of Insurance:_____
    b. Type of Organization:_____
    c. Business insurance on Key Employees:

Name	Amount of Life Insurance Applied For:	In Force:	% Business Owned
1._____	$_____	$_____	_____%
2._____	$_____	$_____	_____ %
3._____	$_____	$_____	_____ %

Attach copies of available company financial reports and financial statements and give name and address of accountant.

REMARKS:
Question:
_____ _____
_____ _____
_____ _____

16. I certify that I have truly and accurately recorded the Proposed Insured(s) answers to this application.
    I also certify that replacement of existing insurance ❑ is ❑ is not involved.

_____ _____ _____
Agent Number Date

Send Policy to: ❑ Agent ❑ Owner

Commission to be split with: Agent: _____ ____%
Agent: _____ ____%
Agent: _____ ____%

Your Family Benefit Life Insurance Company Representative is _____ and he / she can be reached at _____.

Family Benefit Life Insurance Company — Notice to Proposed Insured

Dear Applicant,
Thank you for applying to Family Benefit Life Insurance Company. We greatly appreciate your efforts to complete each part of the application truthfully and accurately. The soliciting agent should be able to answer any questions you may have.

Underwriting:
Once we receive your application, we will begin an evaluation process called underwriting and determine whether you are eligible for the insurance, and if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you applied for, or that we are only able to give you the insurance on a modified basis or at a higher rate. For example, if you currently use tobacco, you will probably not qualify for our lowest rates.

Your application will be our primary source of information, therefore, it must be true, complete and accurate. The information contained in this policy is warranted by you to be true, complete and accurate, and any material misrepresentation or misstatement contained herein may render any policy written as a result of this application void from its inception. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy.

Contestability:
We strongly urge you to review the completed application for accuracy. A claim may be denied or your coverage may be contested by us if the application is incomplete or if it contains fraudulent statements or material misrepresentation. Please be aware that if the application contains materially fraudulent or deceptive statements or conceals material facts, and you submitted it with the intent to defraud or facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime.

Replacement of Existing Coverage:
If you intend to replace existing insurance coverage, tell the agent and answer "yes" to the replacement question. A law of your state of application may require that the agent give you additional information that will help you to compare the policy being applied for and your existing policy. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information needed to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us, or you borrow from an existing policy to pay premium for the insurance you are applying. State law may define replacement to include other situations. Always ask the agent if you are unsure.

Insurance Information Practices:
We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

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

Federal Fair Credit Reporting Act:
As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB, Inc. Disclosure:
Information regarding your insurability will be treated as confidential. Family Benefit Life Insurance Company, 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, Massachusetts 02184-8734.

Family Benefit Life Insurance Company, or its reinsurers, may also release information from 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.

AGENT: Leave this sheet with the applicant.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned declares that:

a. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or for the Insurance Company to determine its obligations under the policy issued in connection with this application.

b. The Insurance Company, its reinsurers, insurance support organizations, consumer reporting agencies and their authorized entities may obtain data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information.

c. I authorize any licensed physician, doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, MIB, Inc., viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other organization, institution or person, that has any records or information about me to release such records or information to the Insurance Company and its reinsurers when this authorization or a copy of it is shown. All sources but the MIB, Inc. may give such records or information to agencies that the Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment or enrollment on whether this Authorization is signed.

d. Any request by the Insurance Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.

e. Data about mental illness, alcoholism, sexually transmitted diseases and the use of drugs are to be included.

f. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.

g. This authorization is good for 24 months after it is signed.

h. The Insurance Company may obtain an investigative consumer report ("inspection report") on me. ❑ Yes, I want to be interviewed if such a report is obtained.

i. I have read this authorization and know my authorized representative or I may request a copy of it. I may revoke this authorization by writing to the Insurance Company.

ACKNOWLEDGEMENT

I, the Proposed Insured (and any Owner signing below), ACKNOWLEDGE that I have been given a copy of the "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and also a copy of the MIB Pre-Notice. I know that this application cannot be processed if I do not sign the authorization below.

TAX CERTIFICATION

Under penalties of perjury, it is certified that (a) the Social Security number(s) or Tax ID number(s) shown in this application are correct taxpayer identification numbers, and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax for failure to report interest or dividends.

AGREEMENT

I, the Proposed Insured (and any Owner signing below) AGREE to the following:

a. I/We have read the application and all statements and answers as they pertain to them, and that these statements and answers are true and complete to the best of their knowledge and belief;

b. The statements and answers in the application are the basis for any policy issued by the company, and that no information about them will be considered to have been given to the company unless it is stated in the application;

c. A sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable;

d. The company will have no liability until (i) A policy is issued on this application and delivered to and accepted by the owner; and (ii) The first premium due is paid in full while each proposed insured is alive. $ _____ has been deposited toward payment of the first premium on the applied for policy.

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.

REPLACEMENT

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

b. 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: _____

Signed at: _____ (City & State) Date: _____

(X) _____ (X) _____ (X) _____

Signature of Proposed Insured | Signature of Parent or Guardian | Signature of Applicant / Owner

(X) _____ (X) _____

Agent Signature | Witness

Agent # _____ _____% Replacement: ❑ is NOT involved

Agent # _____ _____% ❑ is involved

☐ **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)

RESET FORM

AUTHORIZATION & SIGNATURE

I hereby request and authorize any of the Companies named above to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for any policy/certificate(s) listed. This authorization shall be subject to the following conditions:

1. The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified:
2. The Company shall not incur any liability on any transfer returned by the bank;
3. Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;
4. This authorization may be revoked by either party upon 30 days advance written notice, and the Company may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Date	Print Depositor's name EXACTLY as it appears on bank records	Depositor's signature EXACTLY as it appears on bank records
_____	_____	_____

1. NEW APPLICATIONS Mark one payment option and list Insured's first and last name.

☐ Single Payment ☐ Monthly ☐ Quarterly
☐ Semi-Annually ☐ Annually

Insured First Name _____ Insured Last Name _____

2. EXISTING POLICY INFORMATION Mark one payment option and list all existing policies to be paid.

☐ Monthly ☐ Semi-Annually _____ _____ _____
☐ Quarterly ☐ Annually _____ _____ _____

List Insured's Name if not same as Depositor's Name

Insured First Name _____ Insured Last Name _____

3. PAYMENT INFORMATION Complete for any new or exisiting Monthly, Quarterly, Semi-Annually and Annually requests.

Are the premiums being paid with Social Security Benefit deposits? ☐ Yes ☐ No

If "Yes", choose from the following payment dates:
☐ 1st of month ☐ 3rd of month
☐ 2nd Wednesday ☐ 3rd Wednesday
☐ 4th Wednesday

If "No", enter a withdrawal date: _____
Date must be 1st through 28th only. If your scheduled date falls on weekend or holiday, the withdrawal request will be made on the next business day.

4. BANK INFORMATION

Name of Bank _____

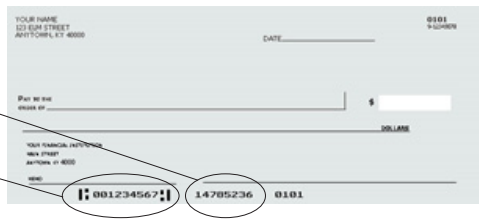
Bank or Branch Address _____

5. ACCOUNT INFORMATION Complete the following OR submit a voided check. Deposit slips not accepted.

Account Type: ☐ Checking ☐ Savings

Depositor's Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Routing Number: ☐☐☐☐☐☐☐☐☐



RESET FORM

CREDIT / DEBIT CARD AUTHORIZATION

RESET FORM

This form must either be faxed or mailed to Family Benefit Life Insurance Co. and then destroyed. It must NOT be submitted by e-mail or other electronic means. A copy of this form should NOT be kept on file.

AUTHORIZATION AND SIGNATURE

I hereby request and authorize Family Benefit Life Insurance Company ("Family Benefit") to charge my credit/debit card identified below for life insurance or annuity premium payments. I understand that these charges will continue until my policy has been paid-up or until I cancel this authorization. This authorization shall be subject to the following conditions:

(1) The preauthorized charge shall occur on or after the premium due dates unless otherwise specified:

(2) Family Benefit shall not incur any liability for additional charges to the credit / debit card account by the bank or credit card company;

(3) Amounts not honored by the bank or credit card company after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;

(4) This authorization may be revoked by either party upon 30 days advance notice, and Family Benefit may immediately revoke this request if any preauthorized charge is dishonored by the bank or credit card company when presented.

Date:	Name as it appears on card	Cardholder's Signature

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

Insured's Name (First, Last) _____ _____

Existing Policy Numbers _____ _____ _____

_____ _____ _____

CARD INFORMATION

Card Type ☐ **Visa** ☐ **Mastercard** ☐ **Direct Express** **CCV (security code)** _____

Credit Card # _____ **Exp Date** _____

Billing Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____

PREMIUM PAYMENT INFORMATION

Payments to be made: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

CREDIT CARD ONLY **Enter date of month if specific charge day is requested (1st – 28th only):** _____

DIRECT EXPRESS DEBIT CARDS ONLY: Process payments on:

☐ 1st of month ☐ 3rd of month ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

RESET FORM

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.)