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MEMBERS Life Insurance Company

P.O. Box 61, 2000 Heritage Way Waverly, IA 50677-0061
1.888.787.8243 or visit www.trustage.com

TruStage™

APPLICATION FOR
Individual Whole Life Insurance

APPLICANT COVERAGE

Name _____

Address _____

City _____ State _____ ZIP _____

Select the amount of Whole Life Coverage

☒ $ _____

☐ Check here only if you do not want the automatic premium loan provision.* (see back)

Primary phone _____

Email address _____

Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of birth ___ ___ / ___ ___ / ___ ___ ___ ___ Gender ☐ Male ☒ Female

Height _____ _____ Weight _____
feet inches lbs

EXISTING INSURANCE AND REPLACEMENT INFORMATION

Do you have any existing life insurance policies or annuity contracts with our company or any other company? ☐ YES ☒ NO

Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company? ☐ YES ☒ NO

Name of company	Amount	Type of coverage	Policy number

BENEFICIARY INFORMATION

Beneficiary Name (s)	Relationship to You	Address

HEALTH INFORMATION

Please answer these questions

1) Have you used tobacco or nicotine products within the past 12 months? ☒ YES ☐ NO

2) Do you require assistance performing activities of daily living such as dressing, bathing, cooking, cleaning, or shopping due to a health condition or injury? ☐ YES ☒ NO

3) Are you currently hospitalized, under hospice care, or do you reside in an assisted living or nursing facility? ☐ YES ☒ NO

4) Other than routine care, in the past 3 months, have you been advised by a licensed medical professional to have surgery, any diagnostic test (other than for HIV) or any procedure which has not been completed or the results are unknown? ☐ YES ☒ NO

Approval is based upon your health and other factors affecting your insurability.

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5) Within the past 5 years, have you been treated or diagnosed by a medical professional for the following? (Check all that apply.) ☐ YES ☒ NO

- ☐ Cancer, except basal cell carcinoma (skin cancer)
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Disease or Condition (except high blood pressure)
- ☐ Chronic Kidney Disease
- ☐ Chronic Lung Disease
- ☐ Chronic Depression or Anxiety
- ☐ Bipolar Disorder or Schizophrenia
- ☐ Dementia or Alzheimer's Disease
- ☐ Head or Brain Injury or Disorder of the Brain or Spinal Nerves
- ☐ ALS (Lou Gehrig's Disease) or Muscular Dystrophy
- ☐ Alcohol or Drug Abuse
- ☐ Cirrhosis of the Liver
- ☐ HIV or AIDS

6) Do you require the use of oxygen? ☐ YES ☒ NO

7) Are you receiving dialysis? ☐ YES ☒ NO

PAYMENT

Deduct

- ☒ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Option 1**Deduct from my**

- ☐ Checking Account
- ☐ Savings Account

☐ **Option 2**** Deduct from my Credit/Debit Card (MC/VISA/Discover Only)

Routing #_____

Account #_____

Financial institution name _____

Account #_____ Expiration date_____

Name of card holder_____

Special remarks_____

Choose your automatic premium deduction date_____
Payments typically process in 1-3 business days (excluding weekends and holidays).

**I authorize by signing below, MEMBERS Life Insurance Company to deduct premiums from the account I've selected for the life coverage applied for on this application. This authorization will remain in effect until revoked by me in writing or by phone. If you leave this section blank, you will receive a bill.

☐ **Option 3** Please send me a bill.

AGREEMENT

I authorize by signing below, that I agree to all **four** of the following statements:

1. I authorize by signing below, that all my statements and answers are true to the best of my knowledge and belief. This application and any supplemental application(s) will be the basis of any insurance issued. I understand: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application, as described in the incontestability provision of the policy; and (2) this insurance becomes effective only if: a.) my application is approved and a policy is issued; b.) my first full premium due is received while I am alive and within 21 days of my policy's effective date; and c.) answers to questions concerning my insurability are as stated in this application. Agents are not authorized to determine insurability, void, waive or change any terms of the application, or make a contract for the Company.

2. I authorize any health care providers, pharmacy benefit manager/ pharmaceutical firm, insurance companies, consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer with information about my physical or mental health condition, substance or alcohol use, STDs, diagnosis or treatment of Human Immunodeficiency Virus (HIV), prescription drug records, financial status, employment status, or other relevant information about me, to give all information (except psychiatric treatment notes) to MEMBERS Life Insurance Company ("Company") or its reinsurers to determine eligibility for insurance or benefits. Such information will be released only to reinsurers, persons performing business duties as delegated or contracted for by the Company related to my application and insurance-related functions, as permitted or required by law, or as I further authorize. Health information shared for these purposes is not subject to federal health information privacy laws; however state privacy laws do apply.

3. I agree this authorization is valid for 24 months or such time limit as permitted in the state where the policy is delivered, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim.

4. I understand that: (1) I can revoke this authorization at any time by written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization, and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits.

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

Required Signature and Date Signed Authorizes Payment and Agreement

TruStage

X

Applicant's Signature Date Signed

***Automatic Premium Loan Provision:** Allows you to borrow against any accumulated cash value from your policy to pay a premium and help prevent policy cancellation. We suggest that you keep this feature.