Lincoln Heritage
LIFE INSURANCE COMPANY

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

PLEASE PRINT LEGIBLY

Executive Offices:
4343 East Camelback Road, Suite 400
Phoenix, AZ 85018-2705

OWNER INFORMATION

Name

Email Phone

Address City State Zip

APPLICANT INFORMATION – *All applicants must permanently reside in the United States.*

Name Relationship to Owner

Address City State Zip

Phone SSN Age Date of Birth Sex

Primary Beneficiary Relationship

Address Phone **Coverage Amount $**

Contingent Beneficiary Relationship **Monthly Premium $**

RIDER OPTIONS

Child Rider ☐Yes ☐No _____ Unit(s) Per Child | AD&D Rider ☐Yes ☐No _____ Unit(s) | **Rider Premium $**

PLAN	PAYMENT METHOD	DUE DATE	
☐ Final Expense	☐ Monthly Draft		
☐ 20 Year Pay	☐ Annual ☐ Quarterly	_____	TOTAL MONTHLY
☐ Modified Death Benefit	☐ Semi-Annual ☐ Monthly Direct	(1st thru 28th only)	PREMIUM $

TOBACCO QUESTION

In the past twelve (12) months, has the applicant used any form of tobacco? ☐ Yes ☐ No

UNINSURABLE CONDITIONS

1. Has the applicant tested positive for HIV or been diagnosed by a physician as having AIDS or a life expectancy of twelve (12) months or less? ☐ Yes ☐ No
2. Is the applicant currently bedridden, hospitalized, in a care facility, or receiving hospice care? ☐ Yes ☐ No

SIGNIFICANT HEALTH CONDITIONS – *If the answer to any health question is "Yes", your death benefit will be modified.*

In the past two (2) years, has the applicant been diagnosed with, been treated by a physician, or taken medication for any of the following conditions:

1. Disease of the heart, including heart attack, heart surgery, or congestive heart failure? ☐ Yes ☐ No
2. Disease of the circulatory system, including stroke, aneurysm, or been advised to have surgery to improve circulation? ☐ Yes ☐ No
3. Cancer, other than basal cell skin cancer? ☐ Yes ☐ No
4. Disease of the lungs, including COPD or emphysema, other than asthma? ☐ Yes ☐ No
5. Disease of the liver or kidney, or had an organ transplant? ☐ Yes ☐ No
6. Alzheimer's disease, dementia, organic brain syndrome, or ALS (Lou Gehrig's disease)? ☐ Yes ☐ No
7. Alcohol or drug abuse? ☐ Yes ☐ No
8. Complications of diabetes, including amputation, diabetic coma, blindness, or kidney disorder? ☐ Yes ☐ No
9. Has the applicant had or been advised to have a diagnostic test relating to any of the questions listed above, except for those relating to the Human Immunodeficiency Virus (AIDS virus), for which results have not yet been received? ☐ Yes ☐ No

REPLACEMENT

1. Does the applicant have existing life insurance or annuity contracts? ☐ Yes ☐ No
2. Will this policy replace or change other insurance or annuities? ☐ Yes ☐ No

If question two (2) is answered "yes", list company and policy #

AUTOMATIC PREMIUM LOAN	DELIVERY
Is Automatic Premium Loan requested? ☐ Yes ☐ No	Mail Policy to: ☐ Owner ☐ Producer

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two (2) years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.

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 affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance. I understand that coverage takes effect when this application has been approved by the Company and the first premium is paid.

Signature of Owner _____ Signature of Applicant _____

Signed in State _____ Date _____

PRODUCER'S CONFIRMATION

Are there existing life insurance and/or annuity contracts on the life of the applicant? ☐ Yes ☐ No To the best of my knowledge, replacement ☐ is ☐ is not involved in this transaction. If replacement is involved, I presented and read the applicant a notice regarding replacement.

Signature of Producer _____ Printed Name _____ Producer's Number _____

FUNERAL CONSUMER GUARDIAN SOCIETY (FCGS) ENROLLMENT – Free Benefit

Please enroll me as a non-voting FCGS member: ☐ Yes ☐ No