MOUNTAIN LIFE INSURANCE COMPANY

SENIOR LIFE PLAN I & II
LIFE INSURANCE
APPLICATION

Mountain Life Insurance Co.
2416 Sir Barton Way Suite 110
Lexington, KY 40509
Toll Free No. 800-888-6542

Please Print Using Dark Ink

PROPOSED INSURED

Name (Last, First, Middle)		Sex M ❑ F ❑	Birth date	Age	Social Security Number	
Home Address: Number and Street, City, State, Zip Code		Place of Birth: State		Height	Weight	Marital Status
Phone No:	U.S. Citizen: ❑Yes ❑No	If "No", Do you have permanent resident status? ❑Yes ❑No				

OWNER

Name (Last, First, Middle)	Sex M ❑ F ❑	Birth date	Age	Social Security Number
Home Address: Number and Street, City, State, Zip Code	Relationship to Insured		Telephone Number	

BENEFICIARY: Primary			BENEFICIARY: Contingent		
Name (Last, First, Middle)	Relationship	Age	Name (Last, First, Middle)	Relationship	Age
1			1		
2			2		

PLAN

☐Senior Life I ☐Senior Life II	Face Amount:	$	Premium Collected	$

Payment Mode: ❑Annual ❑Semi-Annual ❑Quarterly ❑Monthly (PAC/EFT only) **Automatic Premium Loan**: ❑Yes ❑No

HEALTH STATEMENTS

1. Is the Proposed Insured **currently**: Hospitalized, confined to a wheelchair, bed, or nursing facility? .... ❑Yes ❑No
2. Has a physician or medical professional ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ..... ❑Yes ❑No
3. Within the past 12 months has the Proposed Insured been diagnosed by a physician or medical professional with, or received medical treatment, or hospitalization for:
   A. Stroke, angina, heart attack, cardiac or circulatory disease, Chronic Obstructive Pulmonary Disease (COPD), or emphysema? ..... ❑Yes ❑No
   B. Internal cancer, melanoma, kidney failure, Alzheimer's disease or leukemia? ..... ❑Yes ❑No

If any answers to questions 1 – 3B are "Yes", the Proposed Insured is not eligible for ANY coverage.

4. During the past 12 months has the Proposed Insured had: Diagnostic testing recommended by a medical professional which has not been completed or for which the results have not been received, or had treatment or counseling for abuse of alcohol, drugs, or controlled substances?..... ❑Yes ❑No
5. Within the past 24 months has the Proposed Insured been diagnosed by a physician or medical professional with, or received medical treatment, or hospitalization for:
   A. Stroke, angina, heart attack, cardiac or circulatory disease, internal cancer or melanoma? ..... ❑Yes ❑No
   B. Dementia, neuro-muscular disease, Cirrhosis, liver disease, or diabetes?..... ❑Yes ❑No

If any of the answers to questions 4 – 5B are "Yes", the Proposed Insured is eligible only for the Graded Death Benefit Plan (Senior Life II). The Death Benefit will be as follows: Year 1 – 110% of premium paid; Year 2 – 110% of premium paid; Year 3 and thereafter – full face amount.

Would the Proposed Insured accept a Graded Death Benefit (Senior Life II)? ..... ❑Yes ❑No

Will this policy replace any existing life insurance with this or any other Company..... ❑Yes ❑No

DISCLOSURE and AUTHORIZATION

I hereby authorize any medical practitioner, medically related facility, insurance company, the MIB Inc., or other organization, or person that has any records or knowledge of Proposed Insured or his/her health, to give Mountain Life Insurance Company any such information it may require to determine eligibility for insurance. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB. A photographic copy of this authorization shall be as valid as the original. I acknowledge receipt of the *NOTICE REGARDING CONSUMER REPORTS and NOTICE OF DISCLOSURE OF INFORMATION*.

I understand the Company may conduct a telephone interview with Proposed Insured regarding the answers above. I understand and agree the policy applied for will not take effect until issued by the Company and while the Proposed Insured is alive. No agent is authorized to extend, waive or change any terms, conditions or provisions of this policy.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines,and denial of insurance benefits.

I HAVE READ AND FULLY UNDERSTAND THE QUESTIONS AND MY ANSWERS ON THIS APPLICATION. To the best of my knowledge and belief they are true and complete. I understand any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause this policy to become null and void within the contestable period.

Signed at _____ Date _____ Proposed Insured _____
City and State *Signature*

Owner (if other than Proposed Insured) _____
Signature

AGENT STATEMENT – I certify that I have correctly recorded here the information furnished by the Owner and/or Insured.

Date_____Agent _____ Agent No. _____

NOTICE OF INSURANCE INFORMATION PRACTICES

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

NOTICE TO APPLICANT – PART 1. Pursuant to Public Law 91-508, notice is hereby given that as a part of our normal procedure for processing your application, an investigative consumer report may be obtained whereby information is secured through personal interviews with your friends, neighbors, and others with whom you are acquainted. This report, if obtained, typically contains information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information concerning the nature and scope of this report. Please address your request to Mountain Life Insurance Company, 2416 Sir Barton Way Suite 110, Lexington, KY 40509. These reports are obtained in your best interest. They assist us in determining that Mountain Life's insured's meet certain standards, thus allowing us to continue offering coverage at the lowest possible cost to all who qualify.

NOTICE TO APPLICANT – PART 2. Information regarding your insurability will be treated as confidential. Mountain Life Insurance Company or its reinsurers may, however, make a brief report, including protected health information, to MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The MIB phone number is 866-692-6901.

Mountain Life Insurance Company or its reinsurers may also make information in its files, including protected health information, available to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. Information for consumers about MIB may be obtained on it's website at www.mib.com.

CONDITIONAL RECEIPT

No insurance will become effective prior to policy delivery until each and every condition contained in this receipt is met.

Received from_____Date_____the sum of $_____in connection with an application for life insurance, bearing the same date as this receipt on the life of:

_____.

THE CONDITIONS under which insurance will become effective prior to policy delivery are as follows:

1. The amount of payment taken with the application must be not less than the full first premium according to the mode of premium payment selected.
2. Any medical examinations and tests required by the Company must be completed within 45 days of the date of the application.
3. The Proposed Insured must be, on the Effective Date as defined below, a risk acceptable to the Company under its rules, standards and practices for the exact policy and premium applied for, without any modification.

If each and every one of the above conditions have been fulfilled exactly, then insurance as provided by the terms and conditions of the policy applied for will become effective as of the Effective Date, except that the total life insurance in force with the Company on the life of the Proposed Insured, including this amount now applied for shall not exceed:

1. The amount of insurance requested in the application if such amount is less than that specified below; otherwise
2. $100,000 if Proposed Insured is within ages 21 through 65; or
3. $25,000 at all other ages.

"Age" as used herein means age at last birth date.

"Effective Date" as used herein means the latest of:

1. The date the application is signed, or
2. The date of completion of all medical examinations and tests, if required, or
3. The date of issue requested in the application, if any.

A check or draft shall not constitute settlement unless negotiable on the date of this application and honored on the first presentation for payment.

If one or more of the conditions above is not met, liability of the Company shall be limited to the return of the sum received.

Date_____Agent_____

Valid only if signed by an Authorized Company Representative

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Proposed Insured (Please print)	Social Security Number	Birth Date

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. 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 also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

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 physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Mountain Life Insurance 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 Mountain Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and 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 providing written notification to Mountain Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Mountain Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Mountain Life Insurance Company except as authorized by me or as required by law.

I understand that My 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 to release my complete medical record, Mountain Life Insurance 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 any authorized representative or I will receive a copy of this Authorization upon request.

I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal datato Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

MOUNTAIN LIFE
INSURANCE COMPANY

Electronic Funds Transfer Authorization for Mountain Life Insurance Company

I authorize Mountain Life Insurance Company to initiate a monthly electronic funds transfer (EFT) withdrawal from my designated bank account to satisfy the amount of my monthly premium. I authorize my financial institution to accept any withdrawals initiated by Mountain Life Insurance Company.

This authority is to remain in full force and effect until Mountain Life Insurance Company has received written notification from me of its termination in such manner as to afford a reasonable opportunity to act upon it. A new authorization form must be completed if I close the bank account identified below, or if I wish to designate a different bank account. I understand that this authorization does not modify or change any policy provisions.

Policyholder Information

Name:_____

Policy Number (if known):_____

Financial Institution Information

Name of Financial Institution:_____

Address:_____

City:_____State:_____Zip:_____

Routing Number: _____

Account Number:_____

EFT Type: ☐ Checking Account ☐ Savings Account

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Withdrawal Day (1-28): _____

☐ Check here to authorize Mountain Life Insurance Company to draft my account for the initial premium payment and subsequent premium payments subject to the terms of the life insurance contract.

_____ _____

Signature Date

PLEASE ATTACH A VOIDED CHECK TO THIS FORM AND SUBMIT WITH APPLICATION