OXFORD®
LIFE INSURANCE COMPANY

# ASSURANCE

**Application for Individual Whole Life Insurance**
Oxford Life Insurance Company
2721 North Central Avenue, Phoenix, Arizona 85004

**TELEPHONE INTERVIEW 1-888-801-5123**

## SECTION A - PROPOSED INSURED INFORMATION

| NAME (FIRST, MIDDLE INITIAL, LAST) | | | |
|---|---|---|---|
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | GENDER ❑ MALE ❑ FEMALE | PLACE OF BIRTH (CITY, STATE) |
| MAILING ADDRESS | | | EMAIL ADDRESS |
| CITY | STATE | ZIP | TELEPHONE NUMBER |
| STREET ADDRESS (**REQUIRED** IF MAILING ADDRESS IS PO BOX) | | | |
| CITY | | STATE | ZIP |

ARE YOU A U.S. CITIZEN? ❑ YES ❑ NO

IF NO, ARE YOU A LEGAL PERMANENT U.S. RESIDENT? ❑ YES ❑ NO **IF NO, COVERAGE IS NOT AVAILABLE.**

IF YES, PROVIDE THE ALIEN REGISTRATION/USCIS NUMBER AS SHOWN ON YOUR PERMANENT RESIDENT CARD: _____

**SECONDARY ADDRESSEE** – We will send a copy of any notice of late payment or policy lapse to this person.

NAME & ADDRESS: _____

## SECTION B – PROPOSED OWNER (Complete only if the proposed owner is not the proposed insured)

| NAME (FIRST, MIDDLE INITIAL, LAST) | | | |
|---|---|---|---|
| SOCIAL SECURITY OR TAX ID NUMBER | DATE OF BIRTH | ❑ MALE ❑ FEMALE | RELATIONSHIP TO PROPOSED INSURED |
| STREET ADDRESS | | | EMAIL ADDRESS |
| CITY | STATE | ZIP | TELEPHONE NUMBER |

## SECTION C - INSURANCE APPLIED FOR AND PREMIUM PAYMENT MODE

Amount of Insurance Applied for: $_____ Estimated Premium Amount (for selected payment mode): $_____

**REQUESTED POLICY DATE**: _____ (IF LEFT BLANK, THE POLICY DATE WILL BE THE DATE THE POLICY IS ISSUED)

Payment Mode (select one): ❑ Monthly Electronic Funds Transfer (EFT) ❑ Quarterly ❑ Semi-annually ❑ Annually

| PAYOR NAME (IF PAYOR IS NOT PROPOSED OWNER) | RELATIONSHIP TO PROPOSED INSURED |
|---|---|

BILLING ADDRESS (IF BLANK BILLING ADDRESS WILL BE SAME AS POLICY OWNER'S ADDRESS)

Check here if Owner does NOT want the automatic premium loan provision included in the policy: ❑

**MAIL POLICY TO: ❑ Owner ❑ Producer**


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## SECTION D - BENEFICIARIES

**Percentages for each beneficiary class (primary and contingent) must total 100%. Multiple beneficiaries of the same class will share the death benefit equally unless percentages are listed.**

### Primary Beneficiaries

| Name | | Address | |
|---|---|---|---|
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |

### Contingent Beneficiaries

| Name | | Address | |
|---|---|---|---|
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |
| Name | | Address | |
| Date of Birth | Social Security/Tax ID Number | Relationship | Percent |

## SECTION E - EXISTING COVERAGE AND REPLACEMENT

Does the Proposed Insured or the Proposed Owner have any existing life insurance or annuity policies?

❑ Yes ❑ No

Will the purchase of the life insurance policy applied for in this application result in the replacement, termination or change in value of any existing life insurance or annuity policy?

❑ Yes ❑ No

## SECTION F – STRANGER OWNED LIFE INSURANCE

**NOTICE:** State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

HAS THE OWNER, PROPOSED INSURED OR ANY BENEFICIARY ENTERED INTO OR MADE PLANS TO ENTER INTO ANY AGREEMENT TO SELL OR ASSIGN THE OWNERSHIP OF, OR A BENEFICIAL INTEREST IN, THE APPLIED FOR POLICY?

❑ YES ❑ NO **IF YES, PLEASE PROVIDE DETAILS:** _____

## SECTION G – MEDICAL QUESTIONS

**Part 1 - If any question in this Part 1 of Section G is answered yes, or if the proposed insured's height and weight are not within the allowable range, this application will be declined.**

| | |
|---|---|
| 1. What is the proposed insured's height and weight? | H ____ W ____ |
| 2. Have you had, or been advised to have by a member of the medical profession, an organ transplant, or have you been diagnosed by a member of the medical profession as having a terminal illness (an illness that would reasonably be expected to cause death within 12 months), or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure, or do you have paralysis of two or more extremities? | ❑ YES ❑ NO |
| 3. Have you been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related order, or tested positive for the Human Immunodeficiency Virus (HIV)? | ❑ YES ❑ NO |
| 4. Are you currently: hospitalized, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, or receiving Hospice Care? | ❑ YES ❑ NO |
| 5. Have you been diagnosed by a member of the medical profession with diabetes prior to age 30 or have you ever been treated by a member of the medical profession for: insulin shock, diabetic coma, retinopathy, or diabetic neuropathy? | ❑ YES ❑ NO |
| 6. Have you ever been diagnosed by a member of the medical profession, treated or taken medication for: Congestive Heart Failure (CHF) or heart failure, cardiomyopathy, Alzheimer's disease, dementia, schizophrenia, bipolar disorder, organic brain syndrome (acute or chronic mental dysfunction or mental incapacity), Lou Gehrig's disease (ALS), or Huntington's disease? | ❑ YES ❑ NO |
| 7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care? | ❑ YES ❑ NO |
| 8. Within the past 24 months have you been diagnosed or treated by a member of the medical profession for: Internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA), or have you had an amputation caused by any disease? | ❑ YES ❑ NO |
| 9. Have you been diagnosed or treated by a member of the medical profession for more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer? | ❑ YES ❑ NO |
| 10. Within the past 24 months have you:<br>a. been medically diagnosed or treated by a member of the medical profession or taken medication for angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing? | ❑ YES ❑ NO |
| b. been medically diagnosed as having or been treated by a member of the medical profession or hospitalized for heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain? | ❑ YES ❑ NO |
| c. been medically diagnosed or treated by a member of the medical profession for: Hodgkin's disease, cirrhosis, liver disease, systemic lupus (SLE), any neuromuscular disease, cerebral palsy, multiple sclerosis or Parkinson's disease? | ❑ YES ❑ NO |
| 11. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation? | ❑ YES ❑ NO |
| 12. Within the last 5 years have you been treated for, been advised by a medical professional to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or attempted suicide? | ❑ YES ❑ NO |
| 13. Have you been declined or postponed for life or health insurance in the past two years? | ❑ YES ❑ NO |
| 14. Do you currently require human assistance or supervision with any specified activities such as: eating, dressing, toileting, bathing, transferring from bed to chair, walking, or maintaining continence? | ❑ YES ❑ NO |


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| **Part 2 - If any question in this Part 2 of Section G is answered yes, it may not necessarily cause this application to be declined.** | |
|---|---|
| 15. Are you taking or have you been prescribed medication by a member of the medical profession for any impairment in Section G? | ❑ YES ❑ NO |
| 16. Within the past 12 months, have you used any nicotine based products, any form of electronic cigarette (including nicotine-free electronic cigarettes), or marijuana? | ❑ YES ❑ NO |
| 17. Have you applied for life insurance with any other insurance companies in the last two years? | ❑ YES ❑ NO |
| 18. Proposed insured's driver's license number _____ State _____ ❑ None | |

## REPRESENTATIONS, AUTHORIZATIONS AND SIGNATURE

**MEDICAL AND CONSUMER REPORTS AUTHORIZATION (this authorization complies with the HIPAA Privacy Rule):** For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, medical care facility, pharmacy, pharmacy benefit manager, the Veteran's Administration or other health care provider, and any insurance company, insurance support organization (such as MIB, Inc. ("MIB")), insurance laboratories, my employer, consumer reporting agency or state department of motor vehicles, to disclose information about me, including but not limited to, my entire medical record, or any other protected health or consumer information, to Oxford Life Insurance Company ("Oxford Life"), its reinsurers and those who perform services for Oxford Life related to an insurance application or a claim. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness, and the use of alcohol and drugs. I agree that a copy of this authorization or my recorded voice or electronic authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 36 months (or a shorter time period if required by applicable state law) from the date of this application (180 days for HIV-related information), regardless of my condition and whether living or deceased. I can revoke this authorization at any time by written notice to Oxford Life (Attention: Policyholder Services Department, 2721 N. Central Ave., Phoenix, AZ 85004). Revocation will not be effective to the extent that this authorization has been relied upon or to the extent that Oxford Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations (such as the HIPAA Privacy Rule). However, Oxford Life will protect the privacy of health information in accordance with applicable state and federal privacy laws and its own privacy policies. I authorize Oxford Life, or its reinsurers, to make a brief report of my protected health information to MIB. I acknowledge receipt of the MIB Pre-Notice, the Fair Credit Reporting Act Notice and the Privacy Notice. I understand that my health care providers may not condition providing treatment or payment for health care services on my signing of this authorization. I further understand that if I refuse to sign this authorization Oxford Life will not be able to process my application.

_____ Date: _____
Signature of Primary Proposed Insured/Personal Representative

If signed by an individual's Personal Representative, please describe authority to sign on behalf of the individual:

❑ Power of Attorney ❑ Other (please describe): _____

**REPRESENTATIONS AND ACKNOWLEDGEMENTS:**

I have read and understand this application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and fully complete this application. Under penalties of perjury, I certify that I am a U.S. citizen (including a U.S. resident alien) and that my correct taxpayer identification number is shown on this form. All statements and answers in this application are true and complete to the best of my knowledge and belief, are the basis for any policy issued, and will be made a part of the policy. No information about me will be considered to have been given to Oxford Life by me unless it is stated in this application or during the application process.

The producer does not have authority to: accept risk, pass on insurability, waive, make void, change, or modify any provisions, questions or answers given in this application, approve this application, change the policy, or advise me that any inaccurate application response is acceptable.

**NO IMMEDIATE LIFE INSURANCE COVERAGE**.

Oxford Life will have no liability under this application unless, and until: a) the application has been received and approved by Oxford Life at its Home Office; b) the policy has been issued and delivered to the owner during the lifetime of the Proposed Insured; c) the first premium has been paid to and accepted by Oxford Life and honored by the issuing financial institution on the policy applied for; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured remain as stated during the application process.

**WARNING: 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.**

**REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. OXFORD LIFE WILL RELY ON THIS APPLICATION TO DETERMINE INSURABILITY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS BY RESCINDING YOUR POLICY. RESCINDING YOUR POLICY WILL HAVE AN ADVERSE IMPACT ON YOUR INTENDED BENEFICIARY.**

**Signed at (City, State):** _____ **Date:** _____

_____ _____

Signature of Proposed Insured Signature of Proposed Owner

## PRODUCER'S REPORT AND SIGNATURE

Do you have reason to believe that the Proposed Insured or the Proposed Owner has any existing life insurance or annuity policies? ***If yes, a replacement form is always required in states that have adopted the NAIC model replacement regulation, even if the policy applied for in this application will not actually replace any existing coverage.***

❑ Yes ❑ No

Do you have reason to believe that the insurance applied for in this application will result in the replacement, termination or change in value of any existing life insurance or annuity policy? ***If yes, all requested information about any replaced policy must be provided on the replacement form.***

❑ Yes ❑ No

**I certify the following to Oxford Life:** I personally solicited this application and all information recorded on this application is true to the best of my knowledge. The Proposed Insured and Owner seemed to me to be lucid and fully understand all of the questions on this application. If this transaction involves a replacement, I gathered all relevant information regarding the replaced product and determined that the replacement is suitable and in compliance with the Company's position on replacements. To my knowledge, the policy applied for will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Producer's Signature_____ Date _____

Producer's Printed Name _____ Producer's Number _____

## PRIVACY NOTICE

Your privacy is protected. Oxford Life Insurance Company (We, Us, Our), like other insurance companies, sometimes evaluates the medical history and other personal information about applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer your insurance coverage after it is in force.

Any information you give Us regarding your insurability and any information received from other sources will be treated as strictly confidential. In some situations, and in compliance with applicable law, We may disclose information to third parties without further authorization. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which you apply; or (3) your physician or medical professional.

You can make a written request to review personal information about you in Our files. You also may request correction of information you believe to be inaccurate.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. FOR A MORE DETAILED EXPLANATION OF OUR PRIVACY PRACTICES, PLEASE WRITE TO OUR PRIVACY OFFICER AT OXFORD LIFE INSURANCE COMPANY, 2721 NORTH CENTRAL AVENUE, PHOENIX, AZ 85004-1172, OR VISIT WWW.OXFORDLIFE.COM.**

## FAIR CREDIT REPORTING ACT NOTICE

With regard to your application, We may request a consumer report or an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health. No adverse underwriting decision will be made based on your sexual orientation. The information may have been obtained through interviews with you, your neighbors, friends and others who know you. Upon request, We will give you the name and address of the consumer reporting agency so that you may request a copy of the report.

## MIB PRE-NOTICE

Information regarding Your insurability will be treated as confidential. Oxford Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc. ("MIB"), 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, the 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. 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.

Oxford Life Insurance Company, or its reinsurers, may also release information in its file to MIB and 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.

## PREMIUM RECEIPT

I have received a check, or a completed and signed Electronic Funds Transfer ("EFT") authorization for an electronic draft, for the initial premium from the proposed policy payor in the amount of $_____ with the application for life insurance on the life of _____.

(Proposed Insured's Name)

Oxford Life Insurance Company will refund this amount, if collected, if no policy is issued. **This is a premium receipt only**. **It does not provide conditional, temporary or any other insurance coverage**. **If a policy is issued, insurance will be in effect on the Policy Date, provided that the funds for the first premium payment have been paid to and accepted by Oxford Life and honored by the issuing financial institution while the Proposed Insured is alive.**

_____ _____

Producer's signature Date

OXFORD®
LIFE INSURANCE COMPANY

# ASSURANCE

**FINAL EXPENSE LIFE INSURANCE**

## ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

| POLICY NUMBER: | BANK ACCOUNT TYPE: ❑ CHECKING ❑ SAVINGS |
|---|---|
| BANK ACCOUNT OWNER NAME<br>❑ SAME AS INSURED ❑ SAME AS POLICY OWNER or PRINT NAME: | |
| BANK ACCOUNT OWNER ADDRESS | RELATIONSHIP TO INSURED |

| BANK NAME | ROUTING NUMBER | BANK ACCOUNT NUMBER |
|---|---|---|
| | | |

**USE THIS SECTION ONLY IF YOU WANT TO REQUEST A PAYMENT DATE AND POLICY EFFECTIVE DATE THAT COINCIDES WITH YOUR SOCIAL SECURITY PAYMENT DATE.**

**Please make my policy effective date and draft date the:**

❑ Second Wednesday ❑ Third Wednesday ❑ Fourth Wednesday

**Please also write "See EFT Form" next to Requested Effective Date in Section C of the Application.**

**For checking accounts, attach a voided check over this section. For savings accounts, attach a bank account statement. DO NOT ATTACH A DEPOSIT SLIP. A deposit slip may delay processing.**

**Refer to this diagram for instructions on where to locate your bank routing and account numbers.**



Your Name
Your Address

**-VOID-**

Routing Number 123456789 Account Number 1234567

Oxford Life will draft the first premium at the time the policy is effective or issued, whichever is later. Subsequent drafts will occur on the same day of the month as the policy's effective date (or the Social Security payment date if that option is selected).

**I have read, understand and agree to the following:**

I authorize Oxford Life Insurance Company to electronically debit all premiums (at the rate for the payment frequency selected in my application) from the bank account identified above. If the premium for the face amount applied for differs from the estimated premium quoted on an application submitted with this form, I authorize Oxford Life to debit the actual premium amount due from my bank account. This authorization may be terminated by me or by Oxford Life. I may revoke this authorization by written notice to Oxford Life or by calling (866) 641-9999. If this authorization is revoked, Oxford Life will initiate quarterly paper billings. Oxford Life will NOT consider my premium paid if my bank does not honor an EFT request. If a bank return is received due to insufficient funds, Oxford Life will attempt a second draft from your bank account immediately upon notice of the first return. Any bank fees incurred due to bank returns will not be reimbursed by Oxford Life.

**IF THE POLICY OWNER IS NOT THE OWNER OF THE BANK ACCOUNT IDENTIFIED ABOVE, THEN THE BANK ACCOUNT OWNER MUST ALSO SIGN THIS FORM.**

_____ _____

Signature – Policy Owner Date Signature – Bank Account Owner Date

| Oxford Life Mailing Address and Contact Information | | | | | | |
|---|---|---|---|---|---|---|
| **Regular mail or overnight** | **Marketing** | | **New Business** | | **Existing Policies** | |
| 2721 North Central Avenue, Phoenix, AZ 85004 | Phone | 800-308-2318 | Phone | 866-641-9999 | Phone | 866-641-9999 |
| | Fax | 866-380-9691 | Fax | 877-584-2777 | Fax | 877-584-2777 |
| | E-Mail | marketing@oxfordlife.com | E-Mail | fastapps@oxfordlife.com | E-Mail | oxfordphs@oxfordlife.com |