Application for Life Insurance

INSTRUCTIONS TO AGENT

- Before taking this life application, complete the questions required in the Definition of Replacement Form. If any answers are yes, do not take this application until all requirements of Regulation 60 (11/98) are completed.
- Please print clearly with black or blue ink. No felt tip pens.
- Corrections should be initialed and dated by proposed insured/owner. Do not use white out.
- The insured's full name should be shown in Question 1 and signed identically on page 5.
- If the owner is a trust or business please include full title and name of trust or business.
  Ex: Paula Smith, Trustee — Paula Smith Irrev Trust date 1-2-98; Paula Smith, President — Paula's Shoe Store, Inc.
  Make sure that you have the complete name and date of trust and if it is revocable or irrevocable.
- List all owners' tax IDs on page 1. If all owners' tax IDs are not included, we will require completed W-9 before issue.
- Proposed insureds age 15 and over are required to sign the application.
- When insuring the life of children under the age of 15 a parent's signature is required even if they are not the owner of the policy.
- Submit all pages of the application even if information is not required.
- Explain the terms of the company's Conditional Life Insurance Agreement prior to accepting any money with this application.
- Leave the completed Conditional Life Insurance Agreement with the applicant if money is taken.
- Explain the Disclosure Notice and leave it with the Proposed Insured.
- Two applications need to be completed for joint life products—one for each insured.
- If required, send in complete illustration signed by owner and agent. Make sure the application and the illustration match.
- Complete the Pre-Authorized Check Information and attach VOID check if requesting billing mode of PAC.
- Review the application prior to mailing to the company to make certain it is complete and accurate. Include a cover memo with special instructions if needed.
- For faster service, fax the application to 800/875-0223. Please retain original, do not mail.

SPECIAL INSTRUCTIONS TO THE NEW BUSINESS STAFF:

BL 1000 NY (11/05)

INSTRUCTIONS TO PROPOSED INSURED/APPLICANT:

1. Initial any and all changes to the application, do not use whiteout or erasure.
2. A paramedical exam will be set up for your application. To prepare for this visit:
   A. Get a good nights sleep before you visit.
   B. Fast and avoid alcoholic beverages for at least eight hours prior to your visit.
   C. Avoid heavy exercise on the day of your visit.
   D. Avoid tobacco and caffeine products at least one hour prior to your visit.
   E. Drink one or two glasses of water one hour prior to your visit.
   F. Take a few minutes to relax prior to your visit.

BANKERS LIFE OF NY

An AMERUS Company

Home Office: Woodbury, NY

Bankers Life Insurance Company of New York
Mail Processing Center
611 Fifth Avenue
P.O. Box 14539
Des Moines, IA 50306-3539
800/252-4467
800/875-0223 Fax

APPENDIX II

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEM THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?
   YES ____ NO____

2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? YES ____ NO____

3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE INFORCE? YES ____ NO____

4. REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE EXISTING POLICIES? YES ____ NO____

5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? YES ____ NO____

6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? YES ____ NO____

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date:__________________ **Signature of Applicant:** X ____

Date:__________________ **Signature of Applicant:** X ____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: YES ____ NO____

Date:__________________ **Signature of Agent:** ____

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Application for Insurance

(In this application, "Company" refers to Bankers Life Insurance Company of New York.)

APPLICANT INFORMATION

1. PROPOSED INSURED

NAME (FIRST, MIDDLE, LAST) ____________________

ADDRESS ____________________ APT.#______ E-MAIL: ____________________

CITY ____________________ HOME PH. (______) ____________ BUS. PH. (______) ____________

STATE ________ ZIP __________ COUNTY ____________________ SEX ☐ M ☐ F MAIDEN NAME ____________________

BIRTH DATE ______________ BIRTH STATE ____________________ SOCIAL SECURITY NUMBER ____________________

DRIVER'S LICENSE #____________________ STATE ______ MARITAL STATUS ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower

EMPLOYER ____________________ HOW LONG?_______ OCCUPATION/DUTIES ____________________

IF MULTIPLE LIFE PRODUCT, (2ND APP REQUIRED FOR MULTIPLE LIFE)

JOINT INSURED NAMES: (1st): ____________________ (2nd): ____________________

2. OWNER (Insured, unless otherwise indicated) ☐ INDIVIDUAL ☐ BUSINESS ☐ TRUST (date of trust) ____________________

NAME ____________________ BIRTH DATE ____________________

ADDRESS ____________________

CITY ____________________ STATE _______ ZIP ____________ COUNTY ____________

RELATIONSHIP TO PROPOSED INSURED ____________________ SOCIAL SECURITY # OR TAXPAYER ID # ____________________

JOINT OWNER ____________________ SOCIAL SECURITY # OR TAXPAYER ID # ____________________

CONTINGENT OWNER (If none specified, policy provisions will apply.) ____________________

MAIL NOTICES TO ☐ INSURED ☐ OWNER ☐ OTHER (specify) ____________________

OTHER NOTICE ADDRESS ____________________ CITY ____________________ STATE ________ ZIP ____________

3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)
(If necessary, use an additional page for additional details, **signature of owner & date.**)

PRINT FULL NAME	BIRTH DATE	RELATIONSHIP	PERCENTAGE	SOCIAL SECURITY NUMBER

4. CONTINGENT BENEFICIARY(IES)

PRINT FULL NAME	BIRTH DATE	RELATIONSHIP	PERCENTAGE	SOCIAL SECURITY NUMBER

POLICY INFORMATION

5. PRIMARY INSURED ☐ NONSMOKER/NONTOBACCO ☐ SMOKER/TOBACCO

BASE PLAN ____________________ AMT. OF INS. $ ____________________

ADDITIONAL COVERAGE ____________________ AMT. OF INS. $ ____________________ AMT. OF PREM. $ ____________

ADDITIONAL COVERAGE ____________________ AMT. OF INS. $ ____________________ AMT. OF PREM. $ ____________

RIDERS (COMPLETE SUPPLEMENTAL APPLICATION IF APPLICABLE)

☐ WAIVER TYPE ____________________ ☐ OTHER RIDERS (TYPE/AMOUNT): ____________________

☐ SPOUSE RIDER $______________ ☐ CHILD RIDER $______________ ____________________

6. UL DEATH BENEFIT OPTION: ☐ OPTION A LEVEL ☐ OPTION B INCREASING
DIVIDEND OPTION (IF APPLICABLE) ☐ ADD TO ACCOUNT VALUE ☐ CASH

PREMIUM DIRECTION ☐ INTEREST CREDITING STRATEGY 1 Year Point-to-Point _________% 1 Year Monthly Average _________%

1 Year Monthly Cap _________% 1 Year Average Multiple Index _________%

5-YR Fixed-Term _______% 1-YR Fixed-Term _______%

7. WHOLE LIFE APL (IF APPLICABLE) ☐ NO ☐ YES DIVIDEND OPTION ☐ PUA ☐ CASH ☐ REDUCE PREMIUM ☐ OTHER ____________________

PREMIUM INFORMATION

8. PREMIUM PLANNED PREMIUM ____________ ADDITIONAL PREMIUM (Lump Sum) ____________

BILLING FREQUENCY ☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ PAC (Complete Authorization and enclose VOID check.) Other ________

☐ GOVT. ALLOTMENT (if available) ☐ MONTHLY GROUP BILLING List Bill # ____________

HAS THE PREMIUM FOR THE POLICY APPLIED FOR BEEN GIVEN TO THE AGENT IN EXCHANGE FOR THE CONDITIONAL LIFE INSURANCE AGREEMENT? ☐ YES ☐ NO AMOUNT $________ HOW PAID? ☐ CHECK ☐ OTHER (specify) ________

ADDITIONAL POLICY SPECIFICATIONS SAVE AGE ☐ Y ☐ N (Make check payable to Bankers Life)

POLICY DATE (optional)____________ TAX QUALIFICATION TYPE ____________ ☐ SHORT TERM COVERAGE TO POLICY DATE

OTHER____________

NON-MEDICAL INFORMATION

9. LIFE INSURANCE IN FORCE ON PROPOSED INSURED

a. Is any life insurance in force? ☐ Yes ☐ No

If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

b. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? ☐ Yes ☐ No

c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? ☐ Yes ☐ No

d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? ☐ Yes ☐ No

10. OTHER NON-MEDICAL INFORMATION

a. Do you use any form of tobacco or nicotine based products? ☐ Yes ☐ No

If no, have you used any form of tobacco or nicotine based products in the past 5 years? ☐ Yes ☐ No

If yes, when did you last use tobacco or nicotine based products? ____________

Type____________ Quantity____________

b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:

1. In any aviation activity other than as a passenger? ☐ Yes ☐ No
2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? ☐ Yes ☐ No

c. Within the last 5 years, have you filed for bankruptcy (personal or business)? ☐ Yes ☐ No

d. Within the last 5 years, have you been convicted of or plead guilty to reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? ☐ Yes ☐ No

e. Have you been convicted of or plead guilty to an illegal activity in the past, or are you currently under investigation? ☐ Yes ☐ No

f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? ☐ Yes ☐ No

g. Do you intend to travel, or live outside the United States or Canada? ☐ Yes ☐ No

h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.? ☐ Yes ☐ No

i. Complete appropriate supplement or provide details here for any Yes answer in this section. ____________

11. PHYSICIAN INFORMATION

a. Name, address and phone # of your doctor(s) or health care provider(s): ____________

b. When did you last consult a doctor and why? ____________

c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) ____________

MEDICAL INFORMATION If medical exam is required, questions 12-15 do not need to be completed.

COMPLETE QUESTIONS 12 THROUGH 15 TO THE BEST OF THE PROPOSED INSURED'S KNOWLEDGE AND BELIEF

12. PROPOSED INSURED

a. Height in shoes ____________ feet / ____________ inches Weight in clothes ____________ pounds

b. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No

c. Are you now under observation or treatment? ☐ Yes ☐ No

d. Have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)? ☐ Yes ☐ No

e. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No

13. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN SEEN FOR:

a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No

b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? ☐ Yes ☐ No

c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No

d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No

e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No

f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? ☐ Yes ☐ No

g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No

h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No

i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No

j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No

k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No

14. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test (other than an HIV test) or treatment, or been advised to have any diagnostic test (other than an HIV test), surgery or treatment not yet completed? ☐ Yes ☐ No

b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No

c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been convicted of or plead guilty to, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No

d. Do you currently use alcoholic beverages? ☐ Yes ☐ No
If yes, what is the average number of drinks per day? ☐ 2 or less ☐ 3-5 ☐ 6 or more.

15. FAMILY HISTORY

a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No

b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 12 through 15. (If necessary, use an additional page for additional details, **sign by applicant & date.**)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

BL1000NY110503

TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)
Use this form to report the taxpayer identification number (TIN) of the **policy owner.**
Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.
To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).
Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.
Backup Withholding - You are subject to backup withholding if:
(1) You fail to furnish your taxpayer identification number to the payor; OR
(2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
(3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
(4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.
Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.
What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.
Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to Bankers Life Insurance Company of New York (the Company). A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

I agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. The Agent also has no authority to provide any legal or tax advice on behalf of the Company. I agree that all payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the first full premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions, to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information
I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, 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, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information
I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having nonmedical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

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 at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company 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. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification," "Agreements and Representations," "Important Information About the USA Patriot Act," and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

Signed / Dated at ______________________
City, State

X ______________________
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

On ______________________
Date

X ______________________
Signature of Owner if other than Proposed Insured

X ______________________
Signature of Licensed Agent

____
Signature of Joint Owner if other than Proposed Insured

____
Parent/Guardian or Witness (if required)

____
If Owner is a corporation, business firm or trust, give full name and an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

____

____

____

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AGENT'S REPORT All questions must be completed in full

1. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? ☐ Yes ☐ No
   (If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
   1035 Exchange (attach required forms) ☐ External ☐ Internal ____________
2. a. How long have you known the proposed insured? ____________
   b. Is the proposed insured a relative of or does proposed insured have a business relationship with the agent? ☐ Yes ☐ No
   If Yes, explain ____________
   c. Did the agent personally see all the persons to be covered and were answers recorded exactly as given? ☐ Yes ☐ No
   If No, explain and arrange for additional evidence of insurability ____________
3. Is proposed insured(s) a U.S. citizen? ☐ Yes ☐ No If no, how long in U.S.? ____________ Type of Visa? ____________
4. Was any other person present to answer questions? ☐ Yes ☐ No If yes, who and why ____________
5. Does proposed insured and owner speak and understand English? ☐ Yes ☐ No
6. a. **If proposed insured is a minor dependent, complete for all brothers and sisters:**

Age	Sex	Amount of Life Insurance in Force

Age	Sex	Amount of Life Insurance in Force

   b. Amount of life insurance in force on each supporting parent or legal guardian $ ____________
7. Medical requirements arranged ☐ Paramedical Exam ☐ EKG ☐ Blood Analysis ☐ Physician's Exam Date Scheduled ____________
   ☐ Check here if the exam has already been done. Name & Phone # of vendor ____________
8. If Married:
   a. Spouse's name ____________ b. Spouse's occupation ____________
   c. Amount of life insurance in force on spouse $ ____________ d. Spouse's annual earned income $ ____________
9. What is the proposed insured's: Annual earned income $ ____________ Annual unearned income $ ____________ Net worth $ ____________
10. a. Purpose of insurance ☐ Business ☐ Personal ☐ Estate
    (If multi-purpose, give percentage of face or split the amount by purpose in remarks section below.)
    b. If business: ☐ Deferred Comp ☐ Buy/Sell ☐ Split Dollar ☐ Key Person ☐ ____________
    Business net annual income $ ____________ Business net worth $ ____________
    Proposed insured's business life insurance in force $ ____________ % of ownership ____________
    Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount in Force

11. ☐ Additional ☐ Alternate policy: Amount $ ____________ Plan ____________
12. Remarks ____________
    ____

AGENT'S CERTIFICATION

I certify that I saw and know the proposed insured(s) to be the person(s) described in this application and have truly and accurately recorded the information supplied by the applicant, that I know of no condition affecting the eligibility or insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. Other than policy-related information, I have given the proposed insured or owner(s) nothing of value in connection with this application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No. ____________ Agency Name ____________

List of all agents (please print)	Agent code#	Commission share

Signed at ____________ Signed (writing agent) X ____________

Date ____________ Phone # ____________ E-Mail ____________ Fax # ____________

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800 / 252-4467 • 800 / 875-0223 Fax

CONDITIONAL LIFE INSURANCE AGREEMENT

ONLY THE HOME OFFICE HAS AUTHORITY TO MODIFY ANY PROVISIONS ON THIS FORM

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below.
However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this agreement are met.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means “insurable” under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
   a. $500,000 or the amount on page 1 of the application, if the proposed insured is insurable at the rate applied for or better, or
   b. $100,000 or the amount on page 1 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company’s liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:
1. completion of all parts of the application and supplements thereto, OR
2. the date any medical exam (or the date of the second medical exam if required) or other required medical studies or tests are completed, provided such medical examinations, studies or tests are required under the company’s published initial application requirements.

STOP DATE

STOP DATE means the earliest of:
1. the date a non-acceptance notice is mailed from our Home Office, OR
2. the day before the policy date, OR
3. 60 days after the START DATE.

RECEIVED from ______________________ Payment in the Amount of $ ______________________

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BANKERS LIFE INS. CO. OF NY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

The above Conditional Life Insurance Agreement has been read by the undersigned and its terms are agreed to.

The Proposed Insured is ______________________ Signature of Owner X ______________________

I have witnessed the signature(s) of the above on the date set forth herein.

Signed at ______________ ______________ ______________ X ______________________

City State Date Signature of Agent

BANKERS LIFE OF NY
An AMERUS Company
Home Office: Woodbury, NY

Bankers Life Insurance Company of New York
Mail Processing Center: 611 Fifth Avenue • P.O. Box 14539 • Des Moines, IA 50306-3539
800 / 252-4467 • 800 / 875-0223 Fax

DISCLOSURE NOTICE TO PROPOSED INSURED

In this Disclosure, "Company" refers to the insurance company above.
In this Disclosure, "You" and "Your" mean the Proposed Insured.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding Your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life 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 (TTY 866-346-3642) if you are interested in such a disclosure. If you question the accuracy of information in MIB's file, you may contact the MIB information office in writing at Post Office Box 105, Essex Station, Boston, Massachusetts 02112 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The Company or its reinsurers may also release information in its file to insurance support organizations, or to other insurance companies to whom You may apply for life or health insurance or to whom a claim for benefits may be submitted. Insurance support organizations include any person or entity that assembles or collects information about individuals primarily for the purpose of providing such information to an insurance company.

INVESTIGATIVE CONSUMER REPORT

In addition to requesting a report from MIB, as a part of the Company's underwriting process the Company may request an investigative consumer information report to confirm and supplement the information on Your application about Your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover Your mode of living, except as may be related directly or indirectly to Your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with You or Your family, friends, associates, or others with whom You are acquainted. If a consumer information report is requested, You may request to be personally interviewed if You can be contacted during normal business hours. An interview is normally conducted, but You are entitled to make a specific request. You may submit a written request asking to be notified if an investigative consumer report has been prepared. You may also request information on what organization prepared such a report and how to contact that organization.

The Company keeps such information reports confidential and uses them only to evaluate and underwrite Your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If the Company requests a report and the report has an adverse effect on Your insurability, the Company will notify You in writing and give You the name and address of the reporting company.

USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through such financial institutions, including insurance companies.

This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number, and other information as deemed necessary, of all policy owners.**

INFORMATION PRACTICES

Personal information the Company obtains during the underwriting process is private and confidential, and the Company will not disclose it to other persons or organizations without Your written authorization except to the extent necessary to conduct the Company's business, or as permitted or required by law. The Company reserves the right to disclose medical information to a medical professional of Your choice and the right to arrange for an insurance support organization to disclose information on the Company's behalf.

Personal information that may be collected includes mental and physical health conditions, medical history, medical treatment, and information about Your general character, habits, hobbies or avocations, finances, employment, occupation, reputation, or marital status. The information may be collected for the Company by the Company's employees, the Agent, and insurance support organizations that assemble information or prepare investigative consumer reports about You. Information may be collected from personal interviews or by telephone calls with You or Your family, neighbors, friends, business associates, and employers, also from public records, court documents, insurance support organizations and other insurance companies or insurance institutions. If there is a need to contact You by phone, a specially trained representative will call to verify or to ask for additional information relating to the underwriting of Your application.

DISCLOSURE OF INFORMATION AND RIGHT OF ACCESS TO INFORMATION

The Company may disclose personal information about You without prior authorization under certain circumstances. For instance, disclosure may be made to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for the Company, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may give information to accounting firms performing audits, governmental agencies reviewing Company practices, or attorneys hired to protect the Company's legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which You have applied for coverage or benefits. Information may be furnished to agents to aid them in providing adequate service to a policyowner. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing You of a medical problem of which You may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups which conduct studies about risk experience or medical backgrounds of insured lives. No medical record information or personal information relating to Your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

Upon Your written request, the Company will inform You of all persons or entities to whom the Company, the Agent, or any insurance support organization has released Your personal information during the 2 years prior to Your request.

You have a right of access to Your personal information that the Company has collected, and a right to know from what sources it was collected. You may submit a written request to the Company that includes Your full name, address, and policy number and reasonably describes the information desired. The Company will mail the information to You or You may review such personal information in person at one of the Company's offices. The Company will inform You of the nature and substance of the information within 30 days from receipt of the request. The Company will identify sources of information such as hospitals, clinics, doctors, or insurance support organizations. The Company will not identify sources of information where such information was obtained from individuals such as friends or neighbors. The Company will not provide access to information obtained in connection with or in anticipation of a claim for policy benefits, or as part of a civil or criminal proceeding.

You may request that the Company correct, amend, or delete personal information in whole or in part by making written request to the Company. Within 30 days from receipt of the request, the Company will inform You that the Company has either changed such information or the Company will communicate the reasons for not changing such information. If the Company does not make the requested change(s), You may then submit a written statement to the Company setting forth Your opinion regarding the information and/or the reasons why You disagree with the Company's position. All written communications will become part of the policy file.

In any case, the Company will provide either the corrected personal information, or Your request and statement, to all insurance support organizations with whom the Company has shared such information during the previous 7 years. The Company will also notify any specific persons or entities that You direct the Company to inform, who may have received such information during the previous 2 years.

BANKERS LIFE OF NY
An AMERUS Company
Home Office: Woodbury, NY

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800/252-4467 800/875-0223 Fax

Pre-Authorized Check (PAC) Authorization Form

MUST BE COMPLETED IN FULL - (Please print or type all information **except** signatures. Please use black ink.)

Insured: ______________________________

Owner: ______________________________ Telephone No. of Owner: (_____)_____-_________

Owner's Address: ______________________________ Address Change Requested: ☐

CHECK APPROPRIATE BOX

TYPE OF REQUEST:

☐ FIRST REQUEST FOR PAC PLAN - **attach void check***

☐ ADD TO EXISTING PAC UNDER POLICY #______________________

☐ CHANGE OF BANKS, ACCOUNT NUMBER, OR PREMIUM PAYOR - **attach void check***

*For checking account (deposit slips are not acceptable) or for savings accounts, a specification sheet from the bank providing the routing and account numbers to be used for electronic funds transfers (eft).

This form must be received in our office 15 days prior to the draft date.

POLICIES TO BE INCLUDED IN THIS (PAC) PLAN

Policy Number	Insured's Name	Loan Repay Amount

AUTHORIZATION TO HONOR BANK WITHDRAWALS BY:

PREMIUM PAYOR (Print Name as Shown on Financial Institution Records) ______________________

Financial Institution Name ______________________ hereinafter referred to as "You"

Address ______________________

Telephone Number ______________________

Bank Account No. ______________________

Attach void check

The Company may assess a $25 fee if any withdrawal authorized herein is dishonored for any reason.

I hereby request and authorize you to pay and charge to my account debit entries, including checks, drafts and other orders whether by electronic or paper means initiated on my account by the Company, to its own order. This authorization will remain in effect until revoked by me in writing in such time and in such manner as to afford you the Company a reasonable opportunity to act on it, and until you receive such notice, I agree that you shall be fully protected in honoring any such debit entry. In the event you comply with the above request and authorization, I agree that you may at any time cease your participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and the Company.

I further agree that if such debit entry is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by the Company.

X______________________
(Signature of Premium Payor)

X______________________
(Additional signature if joint account)

X______________________
(Signature of Policyholder if other than Premium Payor)

Date______________________

NOTICE AND CONSENT FOR BLOOD OR ORAL FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

BANKERS LIFE OF NY
An AMERUS Company

Bankers Life Insurance Company of New York
Home office: Woodbury, New York

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for a business reason, in connection with insurance you have, or have applied for with the Insurer, the Insurer may disclose these results to others such as affiliates, reinsurers, employees, or contractors. If the Insurer is a member of Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specified blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results, or even that the tests have been done, except as may be required or permitted by law, or as authorized by you.

If your HIV tests are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results, which in the Insurer's opinion are significant. If you desire, you may identify on this authorization form the person to whom you wish to have the specific test results disclosed in the event of an adverse underwriting decision. The person may be yourself, or a physician, or other designee of your discretion.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. You may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results, or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or other policy charges may be necessary.

For further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services, you may contact the New York State Department of Health's state wide toll free number 1-800-541-AIDS.

I have read, and I understand, this Notice of Consent For Blood Testing or Oral Fluid Testing Which May Include HIV Antibody/ Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request, and receive, a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (please print): ____________________ Date of Birth: ____________________

Signature of Proposed Insured: ____________________ Date: ____________________

State of Residence of Proposed Insured: ____

STATEMENT IN LIEU OF CONFORMING ILLUSTRATION

BANKERS LIFE OF NY

An AMERUS Company

Instructions: This form must be completed and returned with the life insurance application if no illustration is used in the sale of presentation of the policy, if the policy is applied for other than as illustrated, or if a computer screen was shown to the applicant but no hard copy was furnished. Please check only one box. This form should not be used as a substitute for providing a compliant illustration at the point of sale whenever possible.

❑ Part A-NO ILLUSTRATION USED IN THE ILLUSTRATED PROCESS. The undersigned agent hereby certifies that an illustration was not used in connection with the application for insurance to Bankers Life of New York submitted by the applicant. The undersigned applicant hereby acknowledges that no illustration was used in connection with the application for insurance.

❑ Part B-THE ILLUSTRATION DOES NOT CONFORM TO THE APPLICATION. The undersigned agent hereby certifies that the policy has been applied for other than as illustrated. The undersigned applicant hereby acknowledges that the illustration viewed does not conform to the policy as applied for.

Representative (Print name)____________________ Signature____________________ Date________

I understand that an illustration conforming to the policy as issued will be provided to me no later than the time the policy is delivered.

Applicant(s) (Print name)____________________ Signature(s)____________________ Date________

Complete this section if an illustration matching the policy as applied for is shown on the computer screen.

❑ Part C-Computer Screen Illustration used, no hard copy furnished to applicant.

I certify that I displayed a computer screen illustration for ____________________ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information.

1. Gender ❑ Male ❑ Female
2. Age____________________
3. Underwriting or rating class____________________
4. Type/name of policy____________________
5. Type(s) of rider(s)____________________
6. Initial death benefit____________________
7. Premium amount illustrated____________________
8. Number of policy years illustrated____________________
9. Assumed number of years of premiums____________________
10. Dividend option election (or application of non-guaranteed elements, if applicable)____________________
11. Guaranteed interest rate____________________
12. Non-guaranteed interest rate(s)____________________

Agent's signature____________________ Date____________________

Agent (Print name)____________________

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than the time the policy is delivered.

Applicant's signature____________________ Date____________________

Agent (Print name)____________________

BANKERS LIFE INSURANCE COMPANY OF NEW YORK
Home office: Woodbury, New York • 1-800-252-4467 • www.blny.com
Mail Processing Center: 611 Fifth Avenue, P.O. Box 14539, Des Moines, IA 50306-3539

BANKERS LIFE OF NY
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Financial Questionnaire

Policy ______________________

Proposed Insured ______________________ Date of Birth ______________________

INSTRUCTIONS–Complete Section I and Section II (Personal Insurance) and/or Section I and Section III (Business Insurance).

SECTION I

A. OTHER LIFE INSURANCE

1. In Force

	Personal	Business	Describe Purpose of Business Insurance
Life	$	$	
Accidental Death	$	$	
Approx. Premium	$	$	

2. Recent, concurrent or contemplated applications to other companies within 90 days prior to or subsequent to this application: (If none, so state.)

Company	Amount	Purpose
	$	
	$	

3. Will any insurance in (2) be purchased in addition to the insurance applied for? . . . . . . ❑ Yes ❑ No
(If yes, explain)

____

B. PERSONAL EARNED INCOME (Annual)

Give last calendar year figures or specify other period here: ______________________

1. Salaried
   - a. Salary $______
   - b. Bonus or Commissions $______
   - c. Other (Describe)*
     - ______ $______
     - ______ $______
   - d. TOTAL COMPENSATION $ ______
2. Self-Employed:
   - a. Gross Income $______
     - less–Business Expenses $______
     - Adjusted Gross income $______
   - b. Other (Describe)*
     - ______ $______
     - ______ $______
   - c. NET EARNINGS $______
3. Spouse's Earned Income $______

*such as dividends, interest, investment income, real estate income, trust funds.

C. Any personal bankruptcies in the past 10 years? . . . . . . ❑ Yes ❑ No
Any business backruptcies in the past 10 years? . . . . . . ❑ Yes ❑ No
(If YES, give date filed, voluntary or involuntary, whether all obligations satisfied and discharged, and date discharged.)

____

D. Are there any personal suits pending or judgments against you at this time? . . . . . . ❑ Yes ❑ No
Are there any business suits pending or judgements against your business at this time? . . . . . . ❑ Yes ❑ No

If yes, explain ______________________

____

____

SECTION II—PERSONAL INSURANCE

(Check at least one block below and provide figures or explanation.)

A. ❑ ESTATE TRANSFER TAXES

PERSONAL WORTH (Current Market Value)

ASSETS		LIABILITIES	
1. Cash in Savings, Stocks, Bonds, Life Ins. Cash Values	$ ________	1. Mortgage or Liens on Real Estate	$ ________
2. Notes & Accounts Receivable	$ ________	2. Notes & Accounts Payable	$ ________
3. Net Business Interest (not included above)	$ ________	3. Unpaid Interest & Taxes	$ ________
4. Real Estate—Residence	$ ________	4. Loans on Life Insurance	$ ________
5. Real Estate—Other (Not included above)	$ ________	5. Other Long-Term Debt	$ ________
6. Personal Property	$ ________	6. Other Liabilities (Describe)	
7. Other Assets (Describe)		________	$ ________
________	$ ________	________	$ ________
________	$ ________	7. TOTAL LIABILITIES	$ ________
8. TOTAL ASSETS	$ ________	NET WORTH	
ESTIMATED ESTATE TRANSFER TAX	$ ________	TOTAL ASSETS minus TOTAL LIABILITIES	$ ________

B. ❑ INCOME REPLACEMENT (Complete D below)

C. ❑ DEBT REPAYMENT or OTHER (Complete D below)

For B or C, explain why the amount of insurance is necessary, including who will suffer a financial loss, how the amount of insurance was determined, and how is it expected that the proceeds will be utilized.)

____

____

____

____

____

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued or in force.

________________________ ________________________

Date Signature of Insured

Agent's Name (please print) ________________________

Agent's Signature ________________ Agent's Telephone No.________ ________________

SECTION III–BUSINESS INSURANCE

1. **Name of Company** ____________________
2. **Nature of Business** ____________________
3. **Type of Organization** ❑ Corporation ❑ Partnership ❑ Sole Proprietorship
4. **Date Organized** ____________________
5. Please attach a copy of your Company's latest audited financial statements (Balance Sheet and Profit & Loss). If not available, complete the following questions:
   a. **Current Company Book Value**
      Assets $__________
      Liabilities $__________
      Net Worth $__________
   b. **Current Company Market Value**
      Market Value $__________
      Insured's % Ownership __________
      Market Value of Insured's % Ownership $__________
   c. **Company Net Profit**–Last Year (Before taxes and bonuses)
      20______ $__________
      This Year (Estimate) $__________
   d. What other Stockholders, Partners, or Key persons are also being insured in favor of the Company? (Give name and amount)
      ____
      ____
6. (Check at least one box and furnish details)

❑ **Key Person**
   a. why is the person to be insured important to the Company? What special skills, knowledge, or abilities does he/she possess which makes insurance necessary? ____________________
   ____
   b. How is it expected that the proceeds will be utilized? ____________________

❑ **Stock Redemption/Buy and Sell**
   a. Is there a written agreement: In effect? (Attach signed copy if yes) . . . . . ❑ Yes ❑ No
      Contemplated? (Give expected finalization date if yes) . . . . . ❑ Yes ❑ No
   b. How is the business being valued in the Agreement? ____________________
   ____
   c. What is the present agreement price? ____________________

❑ **Business Loan**
   a. Name and address of the lender: ____________________
   ____
   b. Amount of Loan $__________ c. Date of Loan: __________
   d. The repayment terms are: ____________________
   ____
   e. The purpose of the loan is: ____________________
   f. Is lender requiring the insurance? . . . . . ❑ Yes ❑ No
   g. Name of others also being insured for same purpose.
      ____________________ Amount $__________
      ____________________ Amount $__________
   h. If the business has a line of credit, give amount: $__________
   i. Have any corporate obligations been personally guaranteed? . . . . . ❑ Yes ❑ No
      (Give amount and description if yes) ____________________

❑ **Other Business purposes** (details) ____________________

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued or in force.

____________________ ____________________
Date Signature of Insured

Agent's Name (please print) ____________________

Agent's Signature ____________________ Agent's Telephone No. __________ __________

BL109080503