PROPOSED INSURED: Name (Last, First, MI) | Birth Date | Birth Place | U.S. Citizen: Yes ☒ No ☐ If no give immigration status/type of visa

Home Phone: | Street:

Business Ph: (| City: | State:

Email: | Sex: M ☐ F ☐ | Married ☐ Single ☐ | Weight:

Social Security # | Occupation / Duties:

Drivers License # | Annual Income: 45,000

Beneficiary and Relationship to Proposed Insured (unless otherwise noted, the beneficiary of the other persons proposed for coverage will be the owner)

Proposed Ins.	Primary	Rel. LOVE	Contingent	Rel.
Spouse/OIR1/JT2	Primary	Rel. AS	Contingent	Rel.
Other Insured 2	Primary	Rel.	Contingent	Rel.
Other Insured 3	Primary	Rel.	Contingent	Rel.

Owner (Unless noted, Owner will be Proposed Insured. Florida applicants may name a secondary addressee to receive notice of lapse, in Special Requests).

Name	Rel.	Social Security #	
Address		Birth Date	Phone # ( )

BASE POLICY INFORMATION Any Form of Tobacco Used in last 12 months: Yes ☒ No ☐ Type and Amt.

Plan Name: ACIGOLD 15-L | Death Benefit Option 1 Level ☐ Increasing | Amt. of Insurance | Planned Prem.

RIDERS AND BENEFITS	Amount	Tobacco Use	RIDERS AND BENEFITS	Amount	Tobacco Use
☐ Waiver of Monthly Deduction	$	Yes ☐ No ☐	☐ Maturity Extension Option	$	Yes ☐ No ☐
☐ Accidental Death Benefit	$	N/A	☐ AIR/Other Insured Rider (1)	$	Yes ☐ No ☐
☐ Childrens Insurance Rider	$	Yes ☐ No ☐	☐ AIR/Other Insured Rider (2)	$	Yes ☐ No ☐
☐ Decreasing Term Rider Yr.	$	Yes ☐ No ☐	☐ AIR/Other Insured Rider (3)	$	Yes ☐ No ☐
☐ Other	$	Yes ☐ No ☐	☐ ROP UL App. 50%	$	Yes ☐ No ☐
☐ Other	$	Yes ☐ No ☐	☐ ROP UL App. 100%	$	Yes ☐ No ☐
☐ Critical Illness Rider	$	Yes ☐ No ☐	☐ Accident Only Disability Income Rider $		Monthly

☒ Modal Premium Amount: $ ☐ Monthly Bank Draft (PAC form) Draft Date (not 29,30,31) ☒ Direct: ☐ Annual ☐ Qtr. ☐ Semi-Annual ☐ Other

Monthly with Mortgage Payment Loan # | Premium Collected for Re

☐ Visa ☐ MasterCard Expiration Date: Credit Card # Signature for Credit Card:

NAME OF OTHER INSUREDS	Occupational Duties	Birthdate	Place of Birth	Height/Weight	Sex	Social Security #	Relationship

AFFIX THIS LABEL TO INSURANCE APPLICATION

0042547486

COMPLETE THE FOLLOWING (Circle each that applies and list names and details in number 10 below).

1. In the last five years have any of the proposed insured's had. A) convictions or citations for motor vehicle violations, or had their driver's license revoked, suspended or limited; B) participated in any type of racing, sky or scuba diving, mountain or rock climbing, or hang gliding; C) flown as other than a passenger, or plan to; D) plan on any foreign travel or residence? Yes ☐ No ☒
2. Does any proposed insured have any existing life or annuity policies? If Yes, please complete the necessary existing policy and replacement notices. Yes ☐ No ☒
3. Will insurance now applied for replace any insurance or annuity? Has any proposed insured ever had an application for life, accident, disability income, critical illness, long term care or health insurance rated or declined, or has any application for any of these pending? Yes ☐ No ☒
4. In the last ten years have any of the proposed insured's been diagnosed or been treated by a member of the medical profession as having any disease or disorder of the: A) heart or circulatory system including, heart attack, chest pain, palpitations, heart murmur, high blood pressure; B) brain or nervous system including seizures, fainting, paralysis, stroke, mental illness or dementia; C) endocrine system including diabetes, or thyroid; D) digestive system including the esophagus, stomach, intestine, liver or pancreas; E) respiratory system including asthma, bronchitis, emphysema; F) urinary or reproductive systems including the kidneys, bladder, prostate; G) muscles or bones, such as arthritis; H) blood or lymph glands; I) or for having tumor, cyst, or cancer? Yes ☐ No ☒

AUTHORIZATION FOR AUTOMATIC PAYMENT PLAN - Not a part of the application for life insurance and will not be included in any policy contract issued.

I authorize the insurance company selected below, hereinafter called the "Company", and the financial institution named below, hereinafter called the "Depository", to initiate electronic debit entries to my Checking/Savings Account indicated below for the payment of insurance premiums on the policies listed on this form. *A voided check for the account is attached.*

Name of Company: **Family Life Insurance Company**

Name of Depository and Branch: | Depository Address:

Name of Depositor: | Policy Number:

RUSH TO

OLIVIA IN

UNDERWRITING =

2. RE FAXED APPS

1 -

2 -

5 PAGES WITH THIS TOP

PLEASE CALL ME AND - TELL ME

WHAT IS PROBLEM - MY MACHINE OR

YOUR MACHINE

thanks

PROPOSED INSURED (Last, First, MI) | Birth Date | U.S. Citizen: Yes ☒ No ☐ If no give immigration status/type of visa:

Home Phone: | Street: | City: | State:

Business Ph: ( ) | Email: | Sex: M ☐ F ☐ | Married ☐ Single ☐ | Height

Social Security # | Occupation / Duties:

Drivers License # | Annual Income: 45,000

Beneficiary and Relationship to Proposed Insured (unless otherwise noted, the beneficiary of the other persons proposed for coverage will be the owner).

Proposed Ins.	Primary	Rel.	Contingent		Rel.
Spouse/OIR1/JT2	Primary	Rel.	Contingent		Rel.
Other Insured 2	Primary	Rel.	Contingent		Rel.
Other Insured 3	Primary	Rel.	Contingent		Rel.

Owner (Unless noted, Owner will be Proposed Insured. Florida applicants may name a secondary addressee to receive notice of lapse, in Special Requests).

Name | Rel. | Social Security #

Address | Birth Date | Phone # ( )

BASE POLICY INFORMATION Any Form of Tobacco Used in last 12 months: Yes ☒ No ☐ Type and Amount

Plan Name | Death Benefit Option: Level ☐ Increasing ☐ | Amt. of Insurance 75,000. | Planned Prem.

RIDERS AND BENEFITS	Amount	Tobacco Use	RIDERS AND BENEFITS	Amount	Tobacco Use
☐ Waiver of Monthly Deduction	$	Yes ☐ No ☐	☐ Maturity Extension Option	$	Yes ☐ No ☐
☐ Accidental Death Benefit	$	N/A	☐ AIR/Other Insured Rider (1)	$	Yes ☐ No ☐
☐ Childrens Insurance Rider	$	Yes ☐ No ☐	☐ AIR/Other Insured Rider (2)	$	Yes ☐ No ☐
☐ Decreasing Term Rider Yr.	$	Yes ☐ No ☐	☐ AIR/Other Insured Rider (3)	$	Yes ☐ No ☐
☐ Other	$	Yes ☐ No ☐	☐ ROP UL App. 50%	$	Yes ☐ No ☐
☐ Other	$	Yes ☐ No ☐	☐ ROP UL App. 100%	$	Yes ☐ No ☐
☐ Critical Illness Rider	$	Yes ☐ No ☐	☐ Accident Only Disability Income Rider $		Monthly

$ Modal Premium Amount: $ ☐ Monthly Bank Draft (PAC form) Draft Date (not 29, 30, 31) ☒ Direct: ☐ Annual ☐ Qtr. ☐ Semi-Annual ☐ Other

Monthly with Mortgage Payment Loan # Lender Total Premium Collected for Receipt $ 20.66

☐ Visa ☐ MasterCard Expiration Date: Credit Card # Signature for Credit Card:

NAME OF OTHER INSUREDS	Occupational Duties	Birthdate	Place of Birth	Height/Weight	Sex	Social Security #	Relationship

AFFIX THIS LABEL TO INSURANCE APPLICATION

0042547486

COMPLETE THE FOLLOWING (Circle each that applies and list names and details in number 10 below).

1. In the last five years have any of the proposed insured's had: A) convictions or citations for motor vehicle violations, or had their driver's license revoked, suspended or limited; B) participated in any type of racing, sky or scuba diving, mountain or rock climbing, or hang gliding; C) flown as other than a passenger, or plan to; D) plan on any foreign travel or residence? Yes ☐ No ☒
2. Does any proposed insured have any existing life or annuity policies? If Yes, please complete the necessary existing policy and replacement notices. Yes ☐ No ☒
3. Will insurance now applied for replace any insurance or annuity? Has any proposed insured ever had an application for life, accident, disability income, critical illness, long term care or health insurance rated or declined, or has any application for any of these pending? Yes ☐ No ☒
4. In the last ten years have any of the proposed insured's been diagnosed or been treated by a member of the medical profession as having any disease or disorder of the: A) heart or circulatory system including, heart attack, chest pain, palpitations, heart murmur, high blood pressure; B) brain or nervous system including seizures, fainting, paralysis, stroke, mental illness or dementia; C) endocrine system including diabetes, or thyroid; D) digestive system including the esophagus, stomach, intestine, liver or pancreas; E) respiratory system including asthma, bronchitis, emphysema; F) urinary or reproductive systems including the kidneys, bladder, prostate, G) muscles or bones, such as arthritis; H) blood or lymph glands; I) or for having tumor, cyst, or cancer? Yes ☐ No ☒

AUTHORIZATION FOR AUTOMATIC PAYMENT PLAN - Not a part of the application for life insurance and will not be included in any policy contract issued.

I authorize the insurance company selected below, hereinafter called the "Company", and the financial institution named below, hereinafter called the "Depository", to initiate electronic debit entries to my Checking/Savings Account indicated below for the payment of insurance premiums on the policies listed on this form. *A voided check for the account is attached.*

Name of Company: **Family Life Insurance Company**

Name of Depository and Branch: | Depository Address:

Name of Depositor: | Policy Number:

Account Number: | Type: ☐ Checking ☐ Savings | Depository Routing #:

Name of Policyholder: | Withdrawal Day:

This program is not a modification of any of the provisions of the policy. The details on the account at the Depository particular notice of premiums being due on the policy. If any electronic debit is dishonored, the payment for insurance will be considered in default according to the terms of the policy. If I have stopped payment of an entry, by notifying my Depository at least 3 business days before the scheduled date of the transfer, I agree to notify the Company immediately of such stopped payment. This authorization is to remain in effect until the Company has received written notification from me of its termination, in such time and manner as to give the Company and Depository a reasonable opportunity to act on it. or it may be automatically discontinued by the Company if any electronic debit is dishonored by the Depository. I agree that if any such debit is dishonored, the Depository shall not be liability even if such dishonor results in the forfeiture of insurance. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U. S. law.

Signature of Depositor: Date: | Signature of Policyholder: Date:

L-9120 FL HOME OFFICE USE ONLY Amount of Payment Increase: Date of Payment Increase: