OLD MUTUAL
FINANCIAL NETWORK

Life Insurance Application

INSTRUCTIONS

Please print on all areas of the application

1. Fill out and sign the life insurance application.
   - ❍ Make sure the ZIP code is included in the primary insured's mailing address (pg. 1).
   - ❍ Remember to fill in the beneficiary's full name and relationship to the primary insured (pg. 1).
   - ❍ Under Product Name (pg. 2), write the marketing name of the plan of insurance.
   - ❍ Remember to fill out the complete addresses and phone numbers for all doctors and hospitals (pgs. 5-6).
   - ❍ Remember to fill out the replacement question in the Agent Certification section (pg. 7).

   Submit application to:

Mailing Address:

Fidelity and Guaranty Life Service Center
P.O. Box 81497
Lincoln, NE 68501

Americom Life and Annuity Service Center
P.O. Box 81337
Lincoln, NE 68501-1337

Overnight Address:

Fidelity and Guaranty Life Service Center
421 South 9th Street, Suite 222
Lincoln, NE 68508

Americom Life and Annuity Service Center
421 S. 9th Street, Suite 222
Lincoln, NE 68508

NOTE: As applicants will automatically be assigned to the best underwriting class for which they qualify, it is <u>not</u> necessary to indicate the desired underwriting class on the application.

2. If the primary insured or owner lives in a state where one of the fraud warnings applies, fill out and sign the "Fraud Warning Notices" page (pg. 8).
3. If the primary insured or owner is applying for spousal coverage, fill in Other Insured section (pg. 1). If Children's Insurance is being applied for, use the Children's Insurance Supplement, Admin 4948.
4. Use the space following the Medical Questions for any "yes" answers. If more space is required to explain any "yes" answers or for any other reasons, fill out the "Additional Information" section (pg. 8) and sign it.
5. For Corporate/Business proposed insureds, fill out the Life Financial Supplement form, Admin 2822. Earned Annual Income is defined as net income after expenses and before taxes.
6. For bank draft payment modes, sign and date the "Bank Draft Plan: EFT Premium Authorization to My Bank" page (final page in application packet). Attach a voided check.
7. Credit card processing is available for the initial payment only. If elected, please be sure to also complete the Mode of Payment section (pg. 2) for subsequent payments.
8. If cash is paid with the application, fill out the "Life Insurance Conditional Receipt" stub (first page after application) and leave it with the applicant. Otherwise, discard it.
9. Leave the page containing the "Investigative Consumer Report Pre-Notification" and the "MIB Pre-Notification" with the applicant (second page after application).
10. All supplemental questionnaires/forms are viewable and orderable on SalesLink at www.omfn.com. Forms are available for the following:

    Motorsports; Residence & Travel; Military; Arthritis; Back Disorders; Diabetes; Growths, Cysts & Tumors; Climbing; Diving; Aviation; Parachuting; Gliding, Hang Gliding and Ultra-Lighting; Children's Insurance; Paramed Form; Reinstatement Application; and Critical Illness Coverage.

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INSURER

❍ Fidelity and Guaranty Life Insurance Company ❍ Americom Life and Annuity Insurance Company

PRIMARY INSURED

Name (First, M.I., Last)

Home Address

Social Security No. | Sex | Marital Status | Date of Birth | Place of Birth | Height (ft., in.) | Weight (lbs.)

Currently Employed? ❍ Yes ❍ No | Occupation and Duties | Place of Employment | Years w/ Current Employer

Earned Annual Income (from last year's W-2) | Drivers License Number and Issue State

Daytime Phone | Evening Phone | Best Time to Call | Email Address

OTHER INSURED

Name (First, M.I., Last) | Relationship to Primary Insured

Home Address

Social Security No. | Sex | Marital Status | Date of Birth | Place of Birth | Height (ft., in.) | Weight (lbs.)

Currently Employed? ❍ Yes ❍ No | Occupation and Duties | Place of Employment | Years w/ Current Employer

Earned Annual Income (from last year's W-2) | Drivers License Number and Issue State

Daytime Phone | Evening Phone | Best Time to Call | Email Address

OWNER(S)

(UNLESS OTHERWISE NOTED, THE OWNER WILL BE THE PRIMARY INSURED.)

Name (First, M.I., Last) | Relationship to Primary Insured

Home Address

Home Phone | Email Address

Birth Date | Social Security No. or Tax I.D. No.

BENEFICIARY DESIGNATION - Primary Insured Coverage

FOR EACH BENEFICIARY, LIST FULL NAME, RELATIONSHIP TO PRIMARY INSURED AND % SHARE.

Primary Beneficiary(ies)	%	Contingent Beneficiary(ies)	%

BENEFICIARY DESIGNATION - Other Insured Coverage

Unless otherwise noted in the Additional Information section, the beneficiary of other persons proposed for coverage will be the Primary Insured.

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POLICY/CERTIFICATE INFORMATION

Product Name	Amount of Insurance	Initial Premium	
	$	$	❍ Nontobacco ❍ Tobacco

TERM: ❍ Level ❍ Decreasing	Term Period (Number of Years)	Premium Guarantee Period

UNIVERSAL LIFE: ❍ Level ❍ Increasing	Planned Premium	Initial Allocation Percentage (for equity-indexed UL products only)
	$	Equity Indexed Interest Option _____% Fixed Interest Option _____%

Mode of Payment (For bank draft, complete Bank Draft Plan authorization, and initial payment required.)

❍ Annual ❍ Quarterly ❍ Bi-Weekly Bank Draft
❍ Semi-Annual ❍ Monthly Bank Draft ❍ Other _____

Payment in Exchange for Conditional Receipt

$

Credit Card (See Instructions Page for current company practice) ❍ Visa ❍ Mastercard	Account Number	Expiration Date	Signature to Authorize Credit Card Charge

(No coverage will be effective except in accordance with the terms of the Receipt and unless full initial modal premium payment is submitted.)

ADDITIONAL BENEFITS - Primary Insured

(Not all riders are available with all products or in all states)

❍ Accelerated Benefit Rider

❍ Accidental Death Benefit Rider — Amount: $_____

❍ Critical Illness Rider — Amount: $_____ *Supplemental questionnaire required.*

❍ Disability Income Rider
Class: _____
Monthly Payout: $ _____
❍ 3 month elimination, 2 year benefit
❍ 6 month elimination, 5 year benefit

❍ Return of Premium Rider

❍ Ultimate Income Option Rider — Initial Lump Sum: $_____ *Illustration required.*
Monthly Income of: $ _____
for _____ years.
Final Lump Sum: $_____

❍ Waiver of Monthly Deduction Rider (UL only)

❍ Waiver of Premium Rider (Term only)

❍ Child Rider — Amount: $_____ *Supplemental questionnaire required.*

❍ Other: _____

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OTHER INSURED BENEFITS

(Not all riders are available with all products or in all states)

❍ Other Insured/Dependent Rider

Amount: $_____

Term Period: _____yrs.

For term products, term period must match base policy term period.

❍ Disability Income Rider

Class: _____

Monthly Payout: $ _____

❍ 3 month elimination, 2 year benefit

❍ 6 month elimination, 5 year benefit

❍ Other:_____

EXISTING INSURANCE

List existing, personal and business life insurance, disability income, annuity, and long term care coverage. Write NONE if there is no coverage.

Insurance Company	Policy Type	Policy #	Life Insurance or Disability Income Amount	ADB Amount	Year Issued

	Primary Insured	Other Insured
1. Will this policy/certificate, if issued, replace, or change any existing life insurance or annuity? If "Yes", circle which policy/certificate(s) listed above are to be replaced or changed. Amount being replaced $_____	❍ Y ❍ N	❍ Y ❍ N
2. Is any other insurance application pending? (If yes, provide details): _____	❍ Y ❍ N	❍ Y ❍ N
3. Have you had any insurance application declined, postponed, rated, modified, or refused for reinstatement? (If yes, provide details): _____ _____ _____ _____ _____	❍ Y ❍ N	❍ Y ❍ N

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PERSONAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Are you a citizen of the United States? If "No", what is your citizenship? Immigration status? Type of visa?	❍ Y ❍ N	❍ Y ❍ N
2. Have you traveled or resided outside the United States or Canada within the past 2 years or plan to do so within the next 2 years?	❍ Y ❍ N	❍ Y ❍ N
3. Have you been convicted of a felony or are currently on parole for any offense?	❍ Y ❍ N	❍ Y ❍ N
4. In the past 10 years have you been convicted of DWI/DUI? In the past 5 years have you had any speeding tickets or other driving violations?	❍ Y ❍ N	❍ Y ❍ N
5. In the past 5 years have you participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, parachuting, mountain or rock climbing, skin or scuba diving, or any similar avocation?	❍ Y ❍ N	❍ Y ❍ N
6. In the past 5 years have you flown as a pilot, student pilot, or crew member of an aircraft?	❍ Y ❍ N	❍ Y ❍ N
7. In the past 10 years have you ever sought or received treatment, advice, or counseling for the use of alcohol?	❍ Y ❍ N	❍ Y ❍ N
8. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?	❍ Y ❍ N	❍ Y ❍ N
9. Within the past 10 years have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	❍ Y ❍ N	❍ Y ❍ N
10. Within the past 7 years, have you filed for bankruptcy?	❍ Y ❍ N	❍ Y ❍ N
11. *(Only required when applying for HomeCertain term insurance)* In the past 13 months have you contracted for a home mortgage, or refinanced an existing mortgage? If the answer is yes, please list the amount of the mortgage or refinancing, and the name and address of the lending institution.	❍ Y ❍ N	❍ Y ❍ N

Detail all Yes answers below (additional information may be required).
In addition, complete questionnaires for YES answers to Questions 2, 5, and 6.

Primary Insured

Other Insured

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PERSONAL PHYSICIAN INFORMATION – Primary Insured

(Provide full name, address, and phone number of personal physician. Please write "NONE" if primary insured does not have a personal physician.)

Name

Date Last Seen

Address

Phone

Reason for Last Visit

Result of Last Visit

PERSONAL PHYSICIAN INFORMATION – Other Insured

(Provide full name, address, and phone number of personal physician. Please write "NONE" if primary insured does not have a personal physician.)

Name

Date Last Seen

Address

Phone

Reason for Last Visit

Result of Last Visit

Life Insurance Application (page 6 of 8)

ADMIN 5010

MEDICAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Have you ever been treated for or diagnosed by a member of the medical profession with:		
a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?	❍ Y ❍ N	❍ Y ❍ N
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?	❍ Y ❍ N	❍ Y ❍ N
c) Any breathing or lung disorders, COPD, asthma, bronchitis, sleep apnea, or emphysema?	❍ Y ❍ N	❍ Y ❍ N
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	❍ Y ❍ N	❍ Y ❍ N
e) Cancer, tumor, or cyst?	❍ Y ❍ N	❍ Y ❍ N
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	❍ Y ❍ N	❍ Y ❍ N
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?	❍ Y ❍ N	❍ Y ❍ N
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	❍ Y ❍ N	❍ Y ❍ N
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?	❍ Y ❍ N	❍ Y ❍ N
j) Any disease or disorder of the skin, eyes, or ears?	❍ Y ❍ N	❍ Y ❍ N
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive test results indicating the presence of the AIDS virus?	❍ Y ❍ N	❍ Y ❍ N
2. Are you currently prescribed any medication?	❍ Y ❍ N	❍ Y ❍ N
3. Have you been prescribed medication in the past 5 years not previously mentioned?	❍ Y ❍ N	❍ Y ❍ N
4. In the past 10 years, have you:		
a) Been hospitalized or had surgery?	❍ Y ❍ N	❍ Y ❍ N
b) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures?	❍ Y ❍ N	❍ Y ❍ N
c) Been recommended to have any test, treatment, or surgery which has not been performed?	❍ Y ❍ N	❍ Y ❍ N
d) Had any illness, disease, or injury that is not included in other answers?	❍ Y ❍ N	❍ Y ❍ N
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?	❍ Y ❍ N	❍ Y ❍ N
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine based product such as patch or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.	❍ Y ❍ N	❍ Y ❍ N

Detail all Yes answers (Include name of treating physician, diagnosis, date of diagnosis, and location of medical records)

Primary Insured

Other Insured

Life Insurance Application (page 7 of 8)

AUTHORIZATION

I have read the questions and answers on this application. The statements made in this application are: complete; true; and correctly recorded. **I agree that: a copy of this application will form a part of any certificate/policy issued; and that no agent can pass on insurability or modify any certificate issued by the Insurer. I also agree that, except as provided in this application's Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) this certificate/policy is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.** I acknowledge that I have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

I authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically-related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to the Insurer, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I also authorize the Insurer to obtain an investigative consumer report on me or on any member of my family who is also applying for life insurance. I understand that I am entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I can reasonably be contacted during normal business hours. Check if interview requested: ❍

I understand that if my coverage includes the Accelerated Benefit Rider and I am later diagnosed with a terminal illness as defined in the rider, I may receive up to 50% of the certificate or policy's death benefit. Since I would receive a portion of my benefits early, the amount payable at the time of my death will be reduced. There is no premium charged for this rider. I understand that receipt of benefits may be taxable, and that the Insurer recommends consultation of a tax advisor prior to exercising this benefit.

I further understand that if I am purchasing a HomeCertain term life product, the mortgage information I supplied will be relied upon to determine my insurability for that product, in conjunction with my health information. As such, inaccurate information about my mortgage may result in a denial, rating, or rescission of my insurance coverage.

I authorize the Insurer and/or its reinsurer(s) to release information in my file to other insurance companies to which I may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 24 months; a photographic copy of this Authorization will be as valid as the original; I, or any of our representatives are entitled to receive a copy of this Authorization.

I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits.

Certification: Under the penalties of perjury, I certify that my Social Security or Tax Identification Numbers provided on this form are true, correct and complete.

Signed at (City and State) on (Date)

Signature of Primary Insured age 15 or more

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

AGENT CERTIFICATION

1) I have asked the questions contained in this application of the Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to the Insurer and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application.

To the best of my knowledge, this application ❍ does replace ❍ does not replace existing life insurance or annuities.

If so, will this replacement be considered a 1035 Exchange? ❍ Yes ❍ No

Signature of Agent | Date

Print Agent's Name | Agent Number

Agent's Phone Number | Agent's Fax Number | Agent's Email Address

Life Insurance Application (page 8 of 8)

ADMIN 5010

Complete and sign this page if additional space is needed or if the primary insured or owner lives in a state where one of the fraud warnings applies.

ADDITIONAL INFORMATION

If additional space is needed to expand on any section, please use the space below.

Section	Question	Primary Insured	Other Insured	Detail
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	

FRAUD WARNING NOTICES

(Please review the notice that applies in your state)

AR/LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY/OH: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. _____ *(Owner's Initials)*.

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

NJ: Any person who includes any false or misleading information on an application for an insurance policy/certificate is subject to criminal and civil penalties.

OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NM/PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Signed at (City and State) on (Date)

Signature of Primary Insured age 15 or more

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

Life Insurance Application

Leave this page with applicant if cash is paid with application.

LIFE INSURANCE CONDITIONAL RECEIPT

PLEASE READ THIS CAREFULLY. **All premium checks must be made payable to:**
❍ **Fidelity and Guaranty Life Insurance Company (hereinafter "Insurer")**
❍ **Americom Life and Annuity Insurance Company (hereinafter "Insurer").**
Do not make check payable to agent/producer or leave payee blank.

Received from _____ a check in the amount of $_____ paid with a life insurance Application to the Insurer. The Application bears the same date as this Receipt. I have advised each proposed insured of the terms, conditions, and limitations of this Conditional Receipt. No agent or broker is authorized to alter the terms of this Receipt, waive any terms or conditions, or pass on insurability.

No agent or broker is authorized to alter the terms of this Receipt, waive any requirements, or pass on insurability.

Dated at (City & State)	On (Date)	Agent's Signature

The life insurance contract you have applied for will not provide insurance coverage unless and until a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective prior to policy/certificate delivery under the following conditions.

This Receipt will provide life insurance starting at the Effective Date. The Effective Date is the latest date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the Application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for the mode of payment chosen is received at our Home Office; or
- Any additional information required by us, including attending physician statement/report, is received at our Home Office.

This Receipt will provide no life insurance unless and until each of the following Requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date hereinabove defined, each person proposed to be insured is found to be insurable exactly as applied for in the Application submitted to the Insurer and in accordance with the Insurer's underwriting rules and standards, without any modification as to life insurance product, amount of life insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen in the Application and is honored immediately upon presentment;
- All medical examinations, tests, and other screenings required by the Insurer are completed, with results received at the Insurer's Home Office within 60 days from the date of the completion of the Application; and
- As of the Effective Date, the health and all factors affecting the insurability of each person proposed to be insured are as stated in the Application.

If all Requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Insurer shall be limited to a full refund to the Applicant of the premium payment received by the Insurer.

This Receipt will terminate on the earliest date of:

- 60 days from the date this Receipt was executed;
- The date the Insurer mails notice to the Applicant of the rejection of the Application for insurance;
- The day before the date insurance goes into effect under the policy/certificate applied for; or
- The date the Insurer offers insurance other than as applied for.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt and any other Conditional Receipt issued by the Insurer on the life of that person, shall be the lesser of the amount applied for or $500,000.

This Receipt provides no insurance for riders or additional benefits.

Life Insurance Application

Leave this page with applicant.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION to Primary Insured And Other Persons Proposed to be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs; sport, hobby or aviation activities; and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know.

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION to Primary Insured And Other Persons Proposed to be Insured, If Any

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to MIB, a not-for-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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 346-3642. 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: Post Office Box 105; Essex Station; Boston, Massachusetts 02112; telephone number (617) 426-3660.

Life Insurance Application

BANK DRAFT PLAN

Please attach a voided check here in addition to your initial premium.

BANK DRAFT PLAN: EFT PREMIUM AUTHORIZATION TO MY BANK

I authorize the payment of debits drawn on my account payable to the insurer, provided there are sufficient funds in said account. I agree that if any such debit be dishonored, the insurer has the right to debit my account the following month for the dishonored debit as well as the scheduled debit for that month. I further agree that if any debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation.

Signature (as it appears on bank records) | Date