

# Life Investors Ultima Products Application Cover Sheet

**Attention: New Business**

**Fax # 800-535-1325**

***Please send an application cover sheet with each application.***

*(Applications can be scanned and e-mailed to us by using the e-mail documents link on agentnetinfo.com.)*

Date: \_\_\_\_\_ Number of pages: \_\_\_\_\_  
(Including cover sheet)

Agent Name: \_\_\_\_\_ Agent Number: \_\_\_\_\_

Agent Phone #: \_\_\_\_\_ Agent Fax #: \_\_\_\_\_

## Proposed Insured Information:

Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ (Only complete if you wish to be contacted at work.)

Best time of day / evening to call: \_\_\_\_\_

Are there any special language needs? \_\_\_\_\_

**Other comments/special instructions:**

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## APPLICATION COMPLETION TIPS

- **Submit a complete and accurate application with necessary supplemental forms.**
- Please **retain your original copy of this fax.** We reserve the right to request the original if we are unable to read the fax.
- Use permanent **black ink. LEGIBLY PRINT** in English.
- **NO** white out. Any changes to written answers must be initialed by applicant/proposed insured.
- **MEDICAL INFORMATION** – Full details must be provided. If additional space is required, please provide on a separate piece of paper signed by Insured/Owner.
- Submit a **copy of check** with application. However, we will require the **original cash or check** in order to place a case and pay commissions.
- Mail **original 1035 form** (if applicable) within **5 working days** of the fax.
- Arrange for necessary **MEDICAL REQUIREMENTS.** Indicate on Agent's report **all requirements ordered.**
- Illustration or Illustration Certification required in **NAIC States** for Universal Life.
- If you wish to mail the **original application**, please indicate that you have previously faxed the application.

**APPLICATION FOR INSURANCE**

[ Standard ]

Life Investors Insurance Company of America  
Home Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

**PROPOSED INSURED INFORMATION**

|  |        |                           |                                   |                 |  |                                     |  |
|--|--------|---------------------------|-----------------------------------|-----------------|--|-------------------------------------|--|
| Name (First, M.I., Last)   |        |                           |                                   | Mailing Address |  |                                     |  |
| Home Telephone No.<br>( )  |        | Work Telephone No.<br>( ) |                                   | Birth Date      | Birth Place (State or Country)   |                                     | E-Mail Address                               |
| Height   | Weight | Marital Status            |                                   | Sex             | U.S. Citizen<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                     | If no, give immigration status/type of visa: |
| Occupation & Duties  |        |                           | Annual Income Current Year _____  |                 |  | Social Security No. or Tax I.D. No. |  |
|  |        |                           | Annual Income Previous Year _____ |                 |  | Drivers License No./ State          |  |
| Net Worth _____  |        |                           |                                   |                 |  |                                     |  |
| Have you used any tobacco within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and when used last _____ |        |                           |                                   |                 |  |                                     |  |

**BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED** (Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)

|         |            |
|---------|------------|
| Primary | Contingent |
|---------|------------|

**OWNER(S)** (Unless otherwise noted, the Owner will be the Insured. For Florida applicants, you may name a secondary addressee to receive notice of possible lapse in coverage - complete the Additional information section.)

|         |                                  |                        |
|---------|----------------------------------|------------------------|
| Name    | Relationship to Proposed Insured | Social Security Number |
| Address | Birth Date                       | Phone<br>( )           |

**POLICY INFORMATION**

|   |                     |                 |
|---|---------------------|-----------------|
| Plan: _____   | Amount of Insurance | Planned Premium |
| <input type="checkbox"/> Level <input type="checkbox"/> Increasing Guarantee Period _____ | \$                  | \$              |

**DISABILITY INCOME**

|   |                    |                          |
|---|--------------------|--------------------------|
| PLAN _____  | AMOUNT: BASE _____ | SIR _____                |
| BENEFIT PERIOD _____                                | ELIM. PER _____    | OCCUPATIONAL CLASS _____ |
| OPTIONAL RIDERS (SPECIFY RIDER, AMOUNT, ETC.) _____ |                    |                          |
|   |                    |                          |
| TOTAL INITIAL DISABILITY INC. PREM. \$              |                    |                          |

Mode of Payment (for bank draft, complete Check-O-Matic authorization, and initial payment required.)  
 Monthly Bank Draft  Quarterly  Semi-Annual  Annual

**BENEFIT/RIDERS**

|  | Benefit Units<br>Monthly \$ Amount |   | Benefit Units<br>Monthly \$ Amount |
|--|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Waiver of Premium Benefit (WP)      | _____                              | <input type="checkbox"/> Income Replacement Rider (IRBR)  | _____                              |
| <input type="checkbox"/> Waiver of Monthly Deduction         | _____                              | Level Term Period (Years) <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 25 <input type="checkbox"/> 30 | _____                              |
| <input type="checkbox"/> Children's Rider                    | _____                              | <input type="checkbox"/> Return of Premium Rider  | _____                              |
| <input type="checkbox"/> Additional Insured Rider (AIR)      | _____                              | <input type="checkbox"/> Unemployment Benefit Rider   | _____                              |
| <input type="checkbox"/> Base Insured Rider (BIR)            | _____                              | <input type="checkbox"/> Other _____  | _____                              |
| <input type="checkbox"/> Accidental Death Benefit (ADB)      | _____                              | <input type="checkbox"/> Other _____  | _____                              |
| <input type="checkbox"/> Guaranteed Insurability Rider (GIR) | _____                              | <input type="checkbox"/> Other _____  | _____                              |

| Name of Other Proposed Insured(s) | Birth Date | Sex | Height | Weight | Social Security Number | Relationship to Insured | Amount of Insurance | Used Tobacco in last 5 years?<br>If yes, list type and when used last |
|-----------------------------------|------------|-----|--------|--------|------------------------|-------------------------|---------------------|---|
|                                   |            |     |        |        |                        |                         |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
|                                   |            |     |        |        |                        |                         |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
|                                   |            |     |        |        |                        |                         |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
|                                   |            |     |        |        |                        |                         |                     | <input type="checkbox"/> Yes <input type="checkbox"/> No              |

| LIFE INSURANCE IN FORCE |                        |             |
|-------------------------|------------------------|-------------|
| Insured's Name          | Company/ Policy Number | Face Amount |
|                         |                        | \$          |
|                         |                        | \$          |
|                         |                        | \$          |
|                         |                        | \$          |

| DISABILITY INCOME - INSURANCE IN FORCE <i>(Complete only if Disability Coverage is being applied for)</i> |                        |                |                |                    |
|---|------------------------|----------------|----------------|--------------------|
| Insured's Name  | Company/ Policy Number | Monthly Amount | Benefit Period | Elimination Period |
|   |                        |                |                |                    |
|   |                        |                |                |                    |

| PERSONAL PHYSICIAN(S)    |   |                                   |
|--------------------------|---|-----------------------------------|
| Name of Proposed Insured | Personal Physician(s) Name, Address, Phone Number | Date Last Visited, Reason, Result |
|                          |   |                                   |
|                          |   |                                   |
|                          |   |                                   |

**GENERAL QUESTIONS** Complete the following. *For YES answers, give full details in the space provided on the next page.*

- Will the insurance applied for replace or change any existing insurance or annuity?  Yes  No
- Have you or any proposed insured,**
- Had any health, disability or life insurance pending or contemplated with another company?  Yes  No
- Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement?  Yes  No
- Within the past 5 years,
  - Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked?  Yes  No  
(If yes, provide state and drivers license number.)
  - Been or is now fully or partially disabled?  Yes  No
  - Been charged with or convicted of any felony or been on probation?  Yes  No
- Within the past 2 years,
  - Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to?  Yes  No
  - Flown other than a passenger, or plan to? (If yes, complete the Aviation Supplement.)  Yes  No
  - Foreign residence or travel contemplated?  Yes  No
- Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use?  Yes  No
- Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60?  Yes  No
- Do you exercise? If yes, describe type, how often per week and how long per session.  Yes  No
- Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions.  Yes  No
- Have you had any weight change in the past year?  Yes  No

**MEDICAL QUESTIONS** Each question must be individually asked and answered. *For YES answers, give full details in the space provided on the next page.*

Within the past 10 years, has any proposed insured been treated or diagnosed by a health care professional as having any disease or disorder of the:

- Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)?  Yes  No
- Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)?  Yes  No
- Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)?  Yes  No
- Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder?  Yes  No
- Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)?  Yes  No
- Endocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)?  Yes  No
- Cancer, tumor, polyps, melanoma or other malignancy?  Yes  No
- Had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test?  Yes  No
- Are you currently under the observation of a physician or taking medication?  Yes  No



## FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

### For applicants in **ARKANSAS, LOUISIANA**

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.

### For applicants in **COLORADO**

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 of Regulatory Agencies.

### For applicants in **FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

### For applicants in **KENTUCKY, OHIO, and PENNSYLVANIA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

### For applicants in **MAINE, VIRGINIA, TENNESSEE and DISTRICT OF COLUMBIA**

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.

### For applicants in **MINNESOTA**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

### For applicants in **NEW JERSEY**

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

### For applicants in **NEW MEXICO**

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 criminal penalties.

**Under penalties of perjury, I hereby certify (1) that the Social Security or Taxpayer I.D. number above on this application is correct and (2) that I am currently not subject to backup withholding. [Cross out (2) if not correct.] See below\*\*\***

The statements and answers on this Application are true and complete to the best of my knowledge and belief. It is agreed that (a) this application and any amendments hereto, shall be the basis of any insurance granted; (b) no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the other Company's rights or requirements or to make or alter any contract; (c) acceptance of any policy issued shall constitute ratification of any endorsements in the space entitled "For Administrative Office Endorsement," except that no change in the amount, classification, plan of insurance or annuity, or benefits shall be effective unless agreed to in writing by the Applicant, and (d) no insurance or annuity shall be considered in force unless and until a policy shall have been issued by the Company and said policy manually received and accepted by the Applicant and the full first premium paid thereon, all during the lifetime and before any change in the insurability of any person proposed for insurance from that stated herein.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

Unless otherwise stated the undersigned Applicant is the Premium Payor and the Owner of the policy applied for.

**AUTHORIZATION:** I authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, Medical Information Bureau, the Veteran's Administration, or other health care provider, my employer and any consumer reporting agency or insurance company who possess information concerning any care, treatment or advice rendered to me to provide such information to Life Investors Insurance Company of America, its representatives or its reinsurers. A photocopy of this Authorization shall be considered as valid as the original, which I or my authorized representative may receive a copy of upon request. Life Investors Insurance Company of America, or its reinsurers, may release this information about me to its reinsurers, to the Medical Information Bureau or to another insurance company to which I have applied. This authorization is limited to a period of 30 months commencing on the date of this application. I represent that the foregoing statements are complete and true to the best of my knowledge and belief. I understand that the date coverage becomes effective for any policy applied for on this application will be the date recorded on the Policy Specification page, not the date the application is signed. I understand coverage will be effective when the first premium is paid, provided all persons proposed for insurance are acceptable to the company under its rules and limits as standard risks, on the plan and for the amount applied for and the rate of premium declared. I authorize payroll deduction of the premiums, and acknowledge receipt of the MIB Disclosure Notice and Fair Credit Reporting Act Notice.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Dated at \_\_\_\_\_ city \_\_\_\_\_ state this \_\_\_\_\_ day of \_\_\_\_\_ month \_\_\_\_\_, \_\_\_\_\_ year

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Additional Insured

\_\_\_\_\_  
Signature of Applicant if Other Than Insured

Owner  Other

\_\_\_\_\_  
Signature of Parent or Legal Guardian for Insured's 15 and under

Best time to call for a personal history interview \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Okay to contact at work? Yes  No

**AGENT INFORMATION & SIGNATURE**

|  |                            |                         |
|--|----------------------------|-------------------------|
| _____<br>Signature of Agent  | _____<br>(Print Last Name) | _____<br>Agent #        |
| (_____)_____<br>Telephone Number   | (_____)_____<br>Fax Number | _____<br>E-mail address |
| _____<br>Split Agent Signature (If Applicable)   | _____<br>(Print Last Name) | _____<br>Agent #        |
| (_____)_____<br>Telephone Number   | (_____)_____<br>Fax Number | _____<br>E-mail address |
| Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? Yes <input type="checkbox"/> No <input type="checkbox"/> |                            |                         |
| If yes, what company? _____  |                            | Policy # _____          |
| <b>SUBMIT SPECIAL REPLACEMENT FORM IF REQUIRED IN YOUR STATE</b>   |                            |                         |

**ILLUSTRATION CERTIFICATION**

I certify that no illustration was used by me or any other authorized agent of Life Investors Insurance Company of America in the sale of the life insurance to \_\_\_\_\_  
 \_\_\_\_\_ APPLICANT  
 on this date. An illustration conforming to the requirements of the \_\_\_\_\_ state regulation  
 \_\_\_\_\_ STATE  
 on illustrations will be delivered to this applicant no later than the policy delivery date.

\_\_\_\_\_  
 DATE AGENT

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

\_\_\_\_\_  
 DATE APPLICANT

**AGENT'S REPORT**

How well do you know proposed insured? \_\_\_\_\_  
 Yes No

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance?  
 (If "yes", explain in Remarks Section)  Yes  No

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)  
 (If "yes", explain in Remarks Section)  Yes  No

Did you see all of those to be insured on the date the application was written?  
 (If "no", explain in Remarks Section)  Yes  No

Is insurance being applied for with any other company?  
 (If "yes", give details in Remarks Section)  Yes  No

Did you witness the signing of the application?  
 (If "no", explain in Remarks Section)  Yes  No

Did you ask each question in this application exactly as printed?  
 (If "no", explain in Remarks Section)  Yes  No

If application is approved other than as requested:  
 Adjust to premium

Issue face amount as shown

Is applicant being examined by a medical doctor?  Yes  No

Is an EKG being arranged?  Yes  No

Is an exercise EKG being arranged?  Yes  No

Is a blood profile being arranged?  Yes  No

**COMPLETE ONLY IF OWNER IS OTHER THAN INSURED**

OWNER IS:  Corporation  Partnership  
 Individual  Sole Proprietorship  Trust

Purpose of Policy  
 Personal Needs Analysis  Estate Liquidity  
 Mortgage  Buy-Sell  
 Retirement  Key Employee  
 Education  Other

If application is for key-man insurance, on what basis was the applicant's value to the business determined?  
 \_\_\_\_\_

Who will pay the premium? \_\_\_\_\_

Total of other insurance on proposed insured payable to business. \_\_\_\_\_  
 If partnership, give names of all partners. \_\_\_\_\_

Are all other partners insured? If not, explain. \_\_\_\_\_

Relationship of owner to Insured? \_\_\_\_\_

How much life insurance is carried by  
 (a) Father \_\_\_\_\_ b) Mother \_\_\_\_\_  
 (c) If this application is greater than a or b above  
 (Explain in Remarks Section)

If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives  
 (in Remarks Section)

|                 |             |            |
|-----------------|-------------|------------|
| 1. Agent's Name | Account No. | % if Split |
| 2. Agent's Name | Account No. | % if Split |

Rate Class:  
Universal  
 Non-Tobacco  
 Tobacco  
 Preferred  
 Preferred Plus  
 Preferred Tobacco  
 Other \_\_\_\_\_

Term  
 Preferred Elite  
 Preferred Plus  
 Preferred  
 Non-Tobacco  
 Preferred Tobacco  
 Tobacco

**ADDITIONAL REMARKS/AND OR SPECIAL INSTRUCTIONS**

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy, if the health of the insured has changed.

\_\_\_\_\_  
 Signature of Writing Agent  
 Print name and account number of, and percentages for agent or agents who are to receive credit and commission.

**PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN**

**Authorization to Insurance Company**

The Premium Payor hereby authorizes Life Investors Insurance Company of America to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Home Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided on the reverse side. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing on the reverse side.

Please attach a voided check or deposit slip.

|   |                       |                          |
|---|-----------------------|--------------------------|
| Bank Name and Address (Name, Office or Branch, Street Address, City, State, Zip Code) |                       |                          |
| Policy Number   | Check-O-Matic Premium | Date of First Withdrawal |

**Authorization to Financial Institution**

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other order's whether by electronic or paper means, with such debits made to my account and drawn or directed by Life Investors Insurance Company of America to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

|                        |  |
|------------------------|--|
| Transit Routing Number | Account Number   |
| Payor Name(s)          | Payor Signature(s) <i>Your signature as on financial institution's records. A copy is as valid as the original</i> |

----- **Detach and leave with applicant if cash is paid with application** -----

**LIFE INSURANCE CONDITIONAL RECEIPT**, Life Investors Insurance Company of America

**Please read this carefully. All premium checks must be made payable to Life Investors Insurance Company of America. Do not make check payable to agent or leave payee blank.**

Received from \_\_\_\_\_ the sum \_\_\_\_\_ paid with a life insurance application to the Company. The application bears the same date as this receipt. There will be no coverage if the sum received is paid by a check which is uncollectible upon initial deposit. The full initial premium payment for the mode of payment chosen is required for this conditional receipt to be effective.

The person(s) proposed to be insured is (are) \_\_\_\_\_

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

|                           |           |                   |
|---------------------------|-----------|-------------------|
| Dated at (City and State) | On (Date) | Agent's Signature |
|---------------------------|-----------|-------------------|

The life insurance contract you have applied for with the Company will not become effective unless and until a contract is delivered to you. Subject to the conditions and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy applied for will become effective prior delivery. No insurance will be provided under this Receipt unless and until all the following requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- **As of the effective date herein defined, each person proposed to be insured is found to be insurable exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;**
- **The payment taken for this Receipt is not less than the full initial premium for the mode of payment chosen in the application;**
- **All medical examinations, tests, and other screenings required by the Company are completed and received at our Home Office within 60 days from the date of the completion of the application; and**
- **As of the effective date, the state of health and all factors affecting the insurability of each person proposed to be insured are stated in the application.**

----- **Detach and leave with applicant** -----

**INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION** to Proposed Insured And Other 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. Ordinarily, it will be provided to third parties only if you authorize us in writing to do so. In rare instances, we may be required to prove some or all of the information without your consent.

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. If you feel any information in our file is incorrect or incomplete, you may ask us to review it. If we agree, we will make any necessary corrections and inform anyone who received such information within the past two years. If we do not agree, you may file a statement of dispute with us. We will send that statement to anyone receiving such information in the past two years. We will also include it in any future disclosure of the disputed information.

**The Financial Institution Named on the Reverse Side**

In consideration of your compliance with the request and authorization on the reverse side of this form, and of your participation in the Check-O-Matic Premium Payment Plan with Life Investors Insurance Company of America, incorporated under the laws of the State of Iowa, (hereinafter called the Company), it is hereby agreed that:

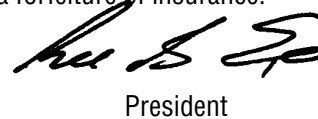
The Company will indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any debit by check, draft, or other order, whether by electronic or paper means, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any cost or expenses reasonably incurred in connection therewith.

The Company will refund to you any amount you have paid to it in error upon receipt of a claim which you may submit at any time up to twelve months after the date of such payment.

The Company will defend, at its expense, any action which might be brought by any depositor, beneficiary, or assignee or any other person because of your actions taken pursuant to the depositor's or the Company's request or in any manner arising by reason of your participation in the Company's Check-O-Matic Premium Payment Plan.

In the event that any such debit shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, the Company will indemnify you for any loss even though dishonor results in a forfeiture of insurance.

  
Secretary

  
President

**Conditions Applicable to Check-O-Matic Premium Payment Plan**

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll Free 1-800-625-4213

Or Write: Life Investors Insurance Company of America, 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

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**Detach and leave with applicant**  
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**LIFE INSURANCE CONDITIONAL RECEIPT (CONTINUED)**

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company shall be limited to a refund to the applicant of the payment made for this receipt.

This receipt will provide insurance starting at the effective date. The effective date is the latest date of the following events:

- Signing of all parts of the application, any supplemental application or addendum to application, or any medical examination.
- Date requested in the application that is acceptable to the Company.
- The last required test(s) and medical examination(s) are performed.
- The full initial premium for the mode of payment chosen is received at our Home Office.
- Any additional information required by us is received at our Home Office.

This Receipt will terminate on the earliest of: (a) 60 days from the date this Receipt was signed; (b) the date the Company mails notice to the applicant of the rejection of the application for insurance and refunds the premium paid; (c) the day before the date insurance goes into effect under the policy applied for; or (d) the date the Company offers insurance other than as applied for.

The aggregate amount of life insurance on each person proposed to be insured which may become effective under this Receipt and any other conditional Receipt issued by the Company will be the lesser of the amount applied for or \$500,000 of the life insurance. This Receipt provides no insurance for riders or additional benefits.

If one or more of this Receipt's conditions have not been met exactly, the Company will be free from any liability except to return the premium payment.

**The Company does not approve and accept the application for insurance within 60 days from the date this Receipt was signed, the application will be deemed to have been rejected by the Company and the Company shall have no liability except to return any payment made for this Receipt on surrender of this Receipt to the Company.**

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**Detach and leave with applicant if cash**  
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**MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION** to Proposed 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 brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105; Essex Station; Boston, Massachusetts 02122; telephone number (617) 426-3660.

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage to which a claim may be submitted.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

|  |                  |                            |
|--|------------------|----------------------------|
| Name of Primary Proposed Insured/Patient   | Date of birth    | Last four digits of SSN    |
| Name of Secondary Proposed Insured/Patient | Date of birth    | Last four digits of SSN    |
| Name(s) of Unemancipated Minors            | Date(s) of birth | Last four digits of SSN(s) |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children (except psychotherapy notes) and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, those containing diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs, and tobacco.
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

|  |      |
|--|------|
| Signature of Primary Proposed Insured/Patient or Personal Representative   | Date |
| Signature of Secondary Proposed Insured/Patient or Personal Representative | Date |

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

Parent       Legal guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): \_\_\_\_\_

**A copy of this authorization will be considered as valid as the original.**