Application for Life Insurance

1905 Teal Road
P.O. Box 7007
Lafayette, Indiana 47903
800-243-6631 • FAX: 888-558-9329
www.lafayettelife.com

The Lafayette Life Insurance Company

INSURANCE INFORMATION PRACTICES

(Includes: Medical Information Pre-Notice and Fair Credit Reporting Act Notice)

One of the prime objectives of Lafayette Life is to provide insurance at a reasonable cost. The underwriting process (evaluation of risks) is necessary not only to assure this reasonable cost, but also to assure that the fair share of the cost is contributed by each policyholder. In considering your application, information from various sources must, therefore, be considered. These include the results of your physical examination, if required, and any reports Lafayette Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Lafayette Life or its reinsurers, may, however, make a brief report to the MIB, Inc., formerly known as, Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

The purpose of MIB is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by MIB may alert the insurer to the possible need for further investigation. MIB is not a repository for medical reports from hospitals and physicians, and information in MIB file does not reveal whether applications for insurance are accepted, rated or declined.

Furthermore, as part of our procedure for processing your insurance application, an investigative consumer report may be prepared. "Consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a person's character, general reputation, personal characteristics, credit standing, or insurability, but not limited to information regarding a person's medical history or condition. Information obtained through personal interviews with your neighbors, friends or others with whom you are acquainted may also be conducted in preparing the consumer report. You have the right to be personally interviewed if we order an investigative consumer report. Please notify your agent should you choose to be interviewed.

You may request and receive from the Company, within 5 (five) business days following the Company's receipt of your request, the name, address, and telephone number of the nearest unit designated to handle inquiries of each consumer reporting agency issuing an investigative consumer report about you at our request. Upon your request, you are entitled to receive a copy of such reporting agencies' consumer reports.

Lafayette Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to ask about personal information which we may have in our files and the right to seek a correction of information you think is wrong.

If you have any further questions or wish to request additional information, please write to Lafayette Life, Attention: Underwriting Department, P.O. Box 7007, Lafayette, Indiana 47903.

FOR THE PROPOSED INSURED TO KEEP

THE LAFAYETTE LIFE INSURANCE COMPANY
1905 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903, Phone: 800-243-6631 Fax: 877-267-4409
APPLICATION FOR LIFE INSURANCE, Type: ( ) Individual ( ) Pension

Part 1: Section I: Proposed Insured

Name: ______ Street Address: ______
City: ______ State: ______ Zip Code: ______-______
Birth Date: ______ Birth State: ______ Age: ______ Sex: ______ Marital Status: ______
Height / Weight: ______ Social Security Number: ______
Home Phone Number: ______ E-mail Address: ______
Occupation: ______ Duties: ______
Business Name and Address: ______
Business Phone: ______ Annual Income: $ ______

Section II: Others Proposed for Insurance (Spouse / Payor Name / SPO - Designated Person / Child(ren))

Spouse / Payor / SPO Full Name	Sex	Birth Date	Birth State	Age	Insurance in Force
					$

Height / Weight	Occupation / Duties	Employer Name & Address	Years Employed

Child(ren) Full Name	Sex	Birth Date	Birth State	Age	Height / Weight	Insurance in Force
						$
						$
						$

Section III: Plan / Riders / Benefits / Amount of Insurance

Base Plan

Base Plan (using Reference Manual wording) ______ Amount of Insurance $ ______
Death Benefit for Universal Life ONLY ( ) Increasing ( ) Level
IUL-07: ______ % A: Annual Point to Point ______ % B: Monthly Average ______ % Fixed (Total must equal 100%)

Insurance Riders / Benefits

______ $ ______ ( ) LPUA $______ $______
(Indicate Type of Term Rider) Initial Annual Premium Maximum Annual Premium

( ) Long Term Care Rider (LTC Rider Packet needed) ( ) SPUA $ ______

( ) SIR $______ ( ) CIR $______ ( ) SPO $______ ( )______ $ ______
( ) ADB $______ ( ) GPO / GIO $______ ( ) Payor Benefit with Waiver of Premium
( ) Waiver of Premium (for Whole Life) ( ) Waiver of Monthly Deduction (UL ONLY) ( ) No-Lapse Premium Waiver (UL ONLY)

Dividend Options: Plan's automatic Option will be used unless otherwise indicated: ______

Premium Billing: Billed Premium Amount $______ Premium Billing Frequency ______ (indicate frequency)

Life Insurance in Force or Application Pending on Proposed Insured:

Company	Amount	Year Issued	Accidental Death
	$		$
	$		$

Existing Policies: Do you have any existing individual life insurance policies and/or annuity contracts in force? ( ) Yes ( ) No
If yes, total amount of existing insurance inforce $______.

Replacement: Is the policy applied for intended to replace, in whole or in part, any existing life insurance or annuity?
( ) Yes ( ) No If Yes, list Company: ______

Automatic Premium Loan Provision:
Automatic Premium Loan Provision will be in effect, if available, unless "No" is selected. ( ) No
(under a Pension Plan, the non-forfeiture option will be reduced paid-up)

Section IV: Proposed Owner (if blank, Proposed Insured is Owner)

Primary Owner:____

Individual or Company or Pension Plan (Trustee Of Plan)

Street Address: ______________________ City, State: ______________ Zip Code: ________

SSN / Tax ID: ______________ Relationship to Insured: ___________ Owner's Age: ______

Contingent Owner: (if blank, Proposed Insured is Contingent Owner)__________________________

Street Address: ______________________ City, State: ______________ Zip Code: ________

SSN/ Tax ID: ______________ Relationship to Insured: ___________ Owner's Age: ______

Section V: Beneficiary (Pension / Profit Sharing Plans: Beneficiary will be Trustee of the Plan named in Section IV above)

Primary Beneficiary	Relationship to Insured	Date of Birth

Contingent Beneficiary	Relationship to Insured	Date of Birth

Part 2: Non-Medical Questions: MUST BE ANSWERED ON ALL APPLICATIONS	Insured		Spouse		Child		SPO/ Payor	
1. Have you or any other person proposed for insurance in the past five (5) years:	Yes	No	Yes	No	Yes	No	Yes	No
a. flown as a pilot, student pilot, or crew member, or is such flying contemplated? (If yes, complete Aviation Questionnaire)								
b. engaged in racing, scuba diving, hang gliding, sky diving, mountain or rock climbing or other hazardous sport or avocation? (If yes, complete applicable questionnaire)								
c. had a drivers license revoked or suspended, had three (3) or more moving violations or accidents, or been convicted for driving under the influence of alcohol or drugs? (If yes, give details, state and license number)								
d. been arrested or convicted for any criminal offense, or are you currently on parole or probation?								
2. Are you or any other person proposed for insurance a current member of any Armed Forces, National Guard or Reserve Unit? (If yes, complete Military Questionnaire)								
3. Are all persons proposed for insurance United States Citizens? (If no, complete Citizenship Questionnaire)								
4. Have you or anyone else proposed for insurance used any form of tobacco in the past three (3) years? (Tobacco includes: cigarettes, cigars, pipe, smokeless, nicotine gum, patch, nasal spray, etc.) If yes, when and what types? Types:______________ Last used (dd/mm/yy):__________								
5. Have you been involved in any discussion about the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider?								
6. Have you ever sold a policy to a life settlement, viatical or other secondary market provider?								
7. Will any portion of the premiums for this policy be financed?								
8. Will any insured or policyowner receive any payment in connection with insurance issued on the basis of this application?								

Details of "Yes" answers:

Part 3: Medical Questions: Required for Simplified Issue and Regular Underwriting	Insured		Spouse		Child		SPO/ Payor	
	Yes	No	Yes	No	Yes	No	Yes	No
9. Have you or anyone else proposed for insurance in the past ten (10) years been diagnosed, treated by or consulted with a medical professional for: a. diabetes, cancer, tumors, high blood pressure, heart disease or heart disorder, circulatory system disorder, disorder of brain, mental or nervous disorder, skin disease, arthritis, connective tissue disease, asthma, chronic obstructive pulmonary disease, disorder of the blood, bladder, intestines, kidneys, liver, lungs, pancreas, stomach or reproductive organs?								
b. an Immune Deficiency Disorder, AIDS or AIDS Related Complex (ARC)?								
10. Have you or anyone else proposed for insurance received medical or surgical treatment or advice from a medical professional for any condition not listed in (9a) in the past five (5) years, including a routine examination?								
11. Have you or any other person proposed for insurance in the past ten (10) years used drugs illegally or been advised by a medical professional to seek or have you been treated for alcohol or drug abuse? (If yes, complete Alcohol / Drug Questionnaire)								
12. Is anyone proposed for insurance now under treatment, observation or taking any medication?								

13. Personal Physician:______________________________ Address:____
Telephone Number:______________________________ Fax #: ____

Details of "Yes" answers

Medical Authorization: I (We) **Authorize** any licensed physician, medical professional or health care provider, hospital, clinic, health care facility or other medical care institution, the Veterans Administration or other institutional source, insurance or reinsuring company, the Medical Information Bureau, Inc., insurance support organization or consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (us) or my (our) minor child(ren) and any other personal or non-medical information of me (us) or my (our) minor child(ren), to give to The Lafayette Life Insurance Company, its legal representative(s), or any consumer reporting agency employed by the Company, any and all such information. I (We) **Understand** the purpose of the authorization is to allow The Lafayette Life Insurance Company to determine eligibility for life insurance or a claim for benefits under a life policy. Any information obtained will not be released by the Company to any persons or organizations **Except** to the Company's reinsurers, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services for the Company in connection with my (our) application or claim. No other release of information may be made except as may be allowed by law or as I (we) may further authorize. I (We) **Know** that I (we) and my (our) authorized representative may receive a copy of this Authorization by requesting it from the Company. I (We) **Acknowledge** receipt of the Insurance Information Practices, which includes the Medical Information Bureau Pre-Notice and the Fair Credit Reporting Act Notice. I (We) **Agree** that a photocopy of this Authorization shall be as valid as the original and that this Authorization will be valid from the date signed below for a period of twenty-four (24) full months, or less if required by applicable state law. I (We) elect to be interviewed if an investigative consumer report is prepared in connection with the application for insurance.

Applicant Statement: I (We) **Agree**: a) that this Application (Part 1, pages 1 and 2; Part 2; and Part 3, if required; and any Supplement to the Application) shall form a part of any Policy issued and constitute the basis for its issue; b) that no agent of Lafayette Life has the authority to approve a policy or waive the provisions of a policy except an officer of the Company; c) changes or corrections made by the Company, if any, will be ratified by my (our) acceptance of the Policy unless written consent is required; and d) **Except as stated in a conditional receipt completed by the company's agent, Lafayette Life grants no insurance under this application unless and until, during the continued insurability of all persons proposed for insurance as stated in the application, the applied-for policy is issued, delivered to the applicant and the first premium therefore is paid.**

I acknowledge that I have received and read the below fraud notice.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief.

$ ____________________ (Must Always Be Answered) has been paid to the agent named below. This payment can in no way obligate The Lafayette Life Insurance Company unless and until all terms or conditions of the corresponding conditional receipt are met.

Signed at ____________________ State of _____________ this __________ day of ____________________ year __________

Signature of Proposed Insured Age 15 & Up

Signature of Proposed Insured Spouse/SPO/Payor

Signature of Parent (Juvenile Policy Only)

Signature of Individual Owner, Trustee or Authorized Officer if Corporate Owner - Authorized Officer must be one of the following:
circle one: President/Vice President General Manager Secretary/Treasurer Owner Partner Chairperson

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Agent Statement: Does the applicant have any existing individual life insurance policies and/or annuity contracts in force to the best of your knowledge? (Yes___) (No___) The insurance applied for (will ___) (will not___) replace any existing life insurance or annuity. The information contained in this application is true and accurate to the best of my knowledge. I have delivered to the proposed insured the Insurance Information Practices which includes the Medical Information Bureau Pre-Notice and the Fair Credit Reporting Act Notice.

Witness ________________________________
Signature of Agent

Agent State License # ____________________ (if required)

Agent's Name ______________________________ Please Print

Authorization for Release of Health-Related Information to The Lafayette Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

____ ______________________________
Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Lafayette Life Insurance Company and it's agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Lafayette Life Insurance 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 any other legally permissible activities that relate to any coverage I have or have applied for with The Lafayette Life Insurance Company.

This authorization shall remain in force for 30 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 in writing, at any time, by sending a written request for revocation to The Lafayette Life Insurance Company at 1905 Teal Road, P.O. Box 7007, Lafayette, Indiana 47903-7007, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent thatThe Lafayette Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Lafayette Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____ ______________________________
Signature of Proposed Insured/Patient or Personal Representative Date

____
Description of Personal Representative's Authority or Relationship to Patient

One copy of this Authorization for Proposed Insured/Patient or Personal Representative
One copy of this Authorization is to be sent to the Home Office

2148 4/03 W

Authorization for Release of Health-Related Information to The Lafayette Life Insurance Company

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____ __________________________
Signature of Proposed Insured/Patient or Personal Representative Date

____
Description of Personal Representative's Authority or Relationship to Patient

One copy of this Authorization for Proposed Insured/Patient or Personal Representative
One copy of this Authorization is to be sent to the Home Office

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
Individual Product Operations: 1-800-243-6631 ext 3751 • Fax: 1-765-477-3298

DISTRICT OF COLUMBIA AIDS PROTOCOL

An individual shall be considered as having been exposed to the Human Immunodeficiency Virus (HIV) if they test positive in both enzyme immunoassay and a Western blot assay.

Definitions:

Enzyme Immunoassay (EIA) means a test licensed by the Federal Food and Drug Administration conducted in accordance with the manufacturer's specifications. EIA tests for examination of serum or plasma, oral fluid, or urine are licensed by the Food and Drug Administration. The EIA must be performed by a laboratory licensed by the U.S. Department of Health and Human Services (or by an equivalent state Department of Health) and enrolled in an approved proficiency evaluation program.

EIA Interpretation: a single test of a specimen found non-reactive is reported as *negative* for HIV infection and no further tests are indicated. A test found reactive is repeated as the same specimen in duplicate, if either of the two duplicates is found reactive the specimen is referred for Western Blot assay.

Western Blot Assay (WB) means an assay licensed by the Food and Drug Administration conducted in accordance with the manufacturer's specifications. WB tests for examination of serum or plasma, or oral fluid, or urine are licensed by the Food and Drug Administration. The WB must be performed on the same specimen found reactive in the EIA by a laboratory licensed by the U.S. Department of Health and Human Services (or by an equivalent state Department of Health) and enrolled in an approved proficiency evaluation program.

WB Interpretation: criteria for *positive* serum or plasma, oral fluid, or urine WB tests are established by the FDA in consultation with the Federal Centers for Disease Control and the Association of State and Territorial Public Health Laboratory Directors. Tests with no WB antibody to HIV are reported as *negative.* Tests with the antibodies which do not meet the criteria for positive are reported as indeterminate. *Indeterminate* findings require follow-up medical and laboratory examinations.

Proportion of False Positive Results Expected with this Protocol

1. Centers for Disease Control. (1992). 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. Mortality and Morbidity Weekly Report, Volume 41:RR-17.

2. Centers for Disease Control (1989). Interpretation and use of Western blot assay for serodiagnosis of Human Immunodeficiency Virus Type I infections. Morbidity and Mortality Weekly Report, Volume 38:S-7.

HIV ANTIBODY TESTING COUNSELING REFERRALS (Form 1556B-DC) on Reverse Side

DELIVER TO PROPOSED INSURED

DISTRICT OF COLUMBIA

HIV ANTIBODY TESTING COUNSELING REFERRALS

Clinica Pueblo
1470 Irving Street, NW
Washington, D.C. 20010
462-4788

Anonymous
Comprehensive pre and post-test counseling.
Free
Walk-in and appointments
Results in 10 days

Planned Parenthood
1108 16th Street, NW
Washington, D.C. 20036
347-8512

Anonymous
Comprehensive pre and post-test counseling.
$40
Appointment required
Results in 72 hours to 1 week

Southwest Health Center
850 Delaware Ave., SW
Washington, D.C. 20024
727-3611

Anonymous
Counseling by a physician or a counselor.
Walk-in and appointments
Results in 2 weeks

Whitman-Walker Clinic
1407 S Street, N.W.
Washington, D.C.
332-5295

Anonymous
Comprehensive pre & post-test counseling, as well as short-term (up to 8 session[s]). Crisis intervention oriented post-test counseling.
Free, although donation requested.
Appointment required
Results in 48 hours or 1 week; depending on appointment schedule

DISTRICT OF COLUMBIA AIDS TESTING PROTOCOL (Form 1556A-DC) on Reverse Side

DELIVER TO PROPOSED INSURED

NOTICE OF CONSENT FORM FOR BLOOD, ORAL FLUID AND/OR URINE SPECIMEN TESTING TO DETERMINE THE PROBABLE CAUSATIVE AGENT OF AIDS

Dear Proposed Insured:

To evaluate eligibility for insurance coverage, it is requested that a sample of blood, oral, and/or urine specimen be provided in order that it may be tested to determine the probable causative agents of AIDS. Signing this form indicates that the procedure used in implementing this test has been explained and has been shown to be in full compliance with the protocol currently adopted by the Commissioner of Public Health for the District of Columbia. Additionally, by signing and dating this form, it is agreed that this test may be performed and that underwriting decisions will be based on the test results.

PRE-TESTING CONSIDERATION:
Many public health organizations have recommended that before taking a test to determine the probably causative agents of AIDS a person should seek counseling in order to become informed concerning the implications of such a test. In the event the test result is positive, one may wish to consider counseling, at his / her expense, subsequent to being tested. A listing of those public and private health care facilities providing such counseling may be obtained from the insurance company.

No insurer shall request or require you to take the testing protocol without first obtaining your or your legal guardian's signature on this consent form. You have the right to decide not to be tested and to not sign this form. Once the insurance company has asked you to sign this consent form, you or your legal guardian may wait 14 days before signing this informed consent.

DISCLOSURE OF TEST RESULTS:
All the test results and the fact that a test occurred will be treated confidentially. The results of the test will be reported to the insurer identified on this form; the applicant or his / her legal guardian; or a physician or health care provider designated on this form by the applicants; a court of competent jurisdiction pursuant to a lawful court order; and any person or entity involved solely in the underwriting process; and any other person or entity expressly named in a separate written authorization signed by the applicant. Results of the test shall not otherwise be disclosed.

NAME OF PHYSICIAN / HEALTH CARE PROVIDER ______________________________

STREET ______________ CITY ______________ STATE ______________ ZIP CODE ______________

MEANING OF POSITIVE TEST RESULTS:

Positive test results may adversely affect your application for insurance. This means that your application may be declined, an increased premium may be charged or other policy changes may be necessary.

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to receive a copy of this form. A certified true photocopy of this form will be as valid as the original.

NOTICE OF RIGHT OF APPEAL:
We are required by law to provide you with the following information:

A named proposed insured who tests positive under the testing protocol certified by the Commissioner of Public Health may appeal to the Commissioner of the Department of Insurance and Securities Regulation to review the testing procedure and result, and may present additional medical evidence, including the result of similar tests for exposure to the probably causative AIDS that the named insured independently obtains, to rebut the positive test result. The Commissioner of the Department of Insurance and Securities Regulation can be reached at the following address: 810 First Street, N.E., Suite 701, Washington, D.C. 20002.

______________________________ Date

______________________________ Signature of Proposed Insured or Parent/Guardian

Form 1556-DC 8/01 W

AGENT'S REPORT (Please complete Sections A thru E in EVERY case)

SECTION A PURPOSE OF INSURANCE * PLEASE ATTACH COPIES OF ANY ILLUSTRATIONS OR SALES MATERIALS USED.

☐ Personal ☐ Key Person ☐ Buy-Sell ☐ Split-Dollar ☐ Estate Planning ☐ Deferred Compensation
☐ Employee Bonus ☐ Mortgage Protection ☐ Mortgage Acceleration ☐ Retirement Planning ☐ Other - Please Explain in Remarks Section

SECTION B PERSONAL AND BUSINESS INFORMATION

1. ANNUAL INCOME — Earned $ ______ Unearned $ ______

Total Assets $ ______ Total Liabilities $ ______ Net Worth $ ______

For amounts over $500,001-$999,999 please complete Financial Questionaire Form 1277

2. How much insurance does spouse have? $ ______

	YES	NO
3. Has any person or business applicant ever filed for bankruptcy?		
4. Are the other owners, partners, officers or key personnel insured?		
5. Any other business insurance in force on the proposed Insured?		

Amount $ ______

Name of Business ______ Date Organized ______ Net Annual Income (Last Year) $ ______ Net Worth (Approximate) $ ______

Name/Title	% Owned	Value of Business Interest	Salary	Amount Carried or Applied - For

SECTION C MEDICAL / INSPECTION REQUIREMENTS

Telecom: ☐ Phone Home ☐ Phone Business
Best Time To Call ______

1. TRIAL APPLICATION
☐ NO ☐ YES (DO NOT order requirements until quote is made)

2. Due to age and amount applied for I have arranged for the following:	BASE INSURED	SPOUSE/SPO PAYOR
MD Examination & Urine Specimen		
Paramedical & Urine Specimen		
Blood Profile with Urine Specimen		
Resting EKG		
Treadmill EKG		
Chest X-ray		
2nd Examination & Urine (if necessary)		

3. Has any proposed insured's name changed within the last 5 years?
☐ NO ☐ YES Previous Name? ______

1035 Exchange Approx. Amount $ ______ Internal: need form 1526 External: need form 1542

SECTION D COMPLETE FOR CIR COVERAGE OR IF APPLICANT IS UNDER AGE 15

	YES	NO
1. Did you see the child or all children proposed for insurance on the date of the application?		
2. Does any child to be covered appear to have any disease or impairment?		
3. Are all eligible children being insured?		

4. Amount of coverage on each parent?

Mother $ ______

Father $ ______

Credit this application to

______ % Code No. ______

______ % ______

Agent telephone number: ______
Agent fax number: ______
Agent e-mail address: ______

REMARKS:

SECTION E AGENT'S FIELD UNDERWRITING

	YES	NO
1. Are you aware of any additional information that was not covered on Part 2 of the application that might affect the insurability of any person to be covered? (If yes, please explain in Remarks Section)		
2. Does the proposed Insured read or speak English?		
a. If no, did you ask the questions in his/her language?		
3. Are you related to the proposed Insured? (If yes, how? ______)		
4. Was this application taken in person? (If no, please explain in Remarks Section)		

5. If this policy will not be delivered in the application state, please indicate the state where delivery will take place: ______

6. How long have you known the proposed Insured? (applicant, if the proposed Insured is under age 15) ______

CONDITIONAL RECEIPT FOR LIFE INSURANCE APPLICATION (Receipt)

NOTE: This Receipt may be used if payment is received on the date the application was signed by the applicant(s)*. **DO NOT** detach this Receipt from the application unless you have received a payment equal to 1/12 of the minimum annual premium. Fill in the amount of this Receipt on the application. As used in this Receipt, "applicant(s)" means the person(s) named as the proposed owner(s) on the application submitted to Lafayette Life.

ALL PREMIUM CHECKS must be made payable to **LAFAYETTE LIFE**. Do not make check payable to the agent or leave payee blank. In addition, all checks must be dated and received on the same date the application was signed.

TO APPLICANT(S): BY ACCEPTING THIS RECEIPT, YOU ACKNOWLEDGE THAT YOU HAVE READ THIS RECEIPT IN ITS ENTIRETY AND THAT YOU UNDERSTAND AND AGREE WITH ALL ITS TERMS, REQUIREMENTS, LIMITATIONS AND EXCLUSIONS. IF YOU DO NOT RECEIVE A POLICY OR A FULL REFUND WITHIN 60 DAYS FROM THE DATE OF THIS RECEIPT, PLEASE MAKE AN INQUIRY DIRECTLY TO THE HOME OFFICE OF LAFAYETTE LIFE AT THE ADDRESS AND/OR PHONE NUMBER STATED ABOVE.

THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNLESS ALL THE REQUIREMENTS OF THIS RECEIPT HAVE BEEN MET. No agent has any authority to waive, modify or otherwise alter any of the terms, requirements, limitations and exclusions of this Receipt. This Receipt is the sole source of all the terms, requirements, limitations and exclusions which apply. Any and all prior representations or statements whether oral or written, are merged into this Receipt.

Received from ______________________________ this __________ day of ________________ ,year _______ the sum of ______________________________ Dollars ($ ____________) in connection with an application for insurance to Lafayette Life.

AMOUNT OF LIFE INSURANCE

The life insurance afforded by this Receipt shall be on the life or lives of the person(s) proposed for insurance in the application, which bears the same number as this Receipt and which has been submitted to Lafayette Life. **IF ANY REQUIREMENT OF THIS RECEIPT IS NOT FULFILLED EXACTLY, LAFAYETTE LIFE'S SOLE LIABILITY SHALL BE FOR THE AMOUNT RECEIPTED FOR ABOVE WHICH SHALL BE PAID TO THE APPLICANT, IF LIVING, OTHERWISE TO THE BENEFICIARY NAMED IN THE APPLICATION**.

REQUIREMENTS FOR INSURANCE

In order for there to be any insurance in effect under this Receipt, **ALL** of the following requirements **MUST** be met;

1. All medical requirements are completed and received by Lafayette Life no later than 60 days from the date of the application; and
2. A sum equal to at least one-twelfth (1/12th) of the annual premium for every proposed insured at standard rates for the plan and amount(s) of insurance requested in paid on the date of the application. (NOTE: In the case of an application for a universal life insurance policy, the sum required is 1/12th of the minimum annual premium or, if applicable, the minimum annual base period premium); and
3. No erasures or alterations, of any type, have been made on this Receipt; and
4. Any check issued in payment of the required premium is honored upon its presentment for payment; and
5. All questions on the application and any medical examination questionnaire have been answered; and
6. All answers given in the application and on any medical examination questionnaire are true and complete; and
7. All persons proposed for insurance were, as of the date of the application, acceptable to Lafayette Life, in accordance with its underwriting rules and practices, at a standard risk for the amount and plan of insurance for which application was made to Lafayette Life.

EFFECTIVE DATE OF COVERAGE

If all the requirements stated above are met exactly, then the insurance afforded by this Receipt shall take effect on the latest of the following:

1. The date of the application (which bears the same number as this Receipt); or
2. The date all medical requirements are received by the Lafayette Life at its Home Office in Lafayette, Indiana; or
3. The effective date requested on the application (which bears the same number as this Receipt).

EXPIRATION FROM COVERAGE

If all the requirements stated above are fulfilled exactly, then the insurance provided under this Receipt will extend only until the earlier of 60 days from the effective date of this Receipt or the date the application is approved at the Home Office of Lafayette Life.

EXCLUSIONS FROM COVERAGE

This Receipt, during the period it is in effect, provides no coverage for any person who commits suicide, whether sane or insurance or during commission of a felony. Lafayette Life's sole obligation in such a case will be to return the sum receipted for above. **NO INSURANCE AMOUNT SHALL BE PAYABLE.** This Receipt **DOES NOT** provide any coverage for accidental death even if such a benefit was requested on the application.

LIMITS ON THE AMOUNT OF INSURANCE

The amount of life insurance granted by this Receipt, and all other receipts of Lafayette Life in effect on the same person(s) at the same time shall not exceed $250,000 if the person is age 0-70 years of age. **THIS RECEIPT PROVIDES NO COVERAGE AS TO ANY PERSON PROPOSED FOR INSURANCE WHO IS 71 YEARS OF AGE, OR OLDER, ON THE DATE OF THIS RECEIPT.**

COUNTERSIGNED BY:

THE LAFAYETTE LIFE INSURANCE COMPANY

__________________________________ , AGENT

Secretary

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

The Lafayette Life Insurance Company is required by law to request the following information:

POLICYOWNER: ______________________________

ADDRESS: ______________________________

TAXPAYER IDENTIFICATION NUMBER:
Social Security Number ______/______/______ Employer Identification Number ______/______

NOTE: If the proposed owner is the Trustee of a pension plan or Trustee of a Trust, give the name and Employer Identification Number of the PENSION PLAN OR TRUST. (DO NOT FURNISH NUMBER OF THE TRUSTEE.)

CERTIFICATION - Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), AND
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I am a US person (including a U.S. resident alien).

CERTIFICATION INSTRUCTIONS - You must cross out item 2 if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

______________________________ ______________________________
Date Signature of Policyowner

THE ABOVE FORM IS REQUIRED ONLY FOR THE FOLLOWING SITUATIONS:
Dividend Option 'Accumulate at Interest'
Dividend Option OYD 'Accumulate at Interest with One Year Term Insurance'
Premium Deposit Fund

SPECIFIC INSTRUCTIONS FOR FORM W-9

PRIVACY ACT NOTICE - Section 6109 of the IRS Code requires you to furnish your correct Taxpayer Identification Number (TIN) to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. You must provide your TIN whether or not you are required to file a tax return. By law, we must generally withhold 31% of taxable interest, dividend, and certain other payments to you if you do not furnish us with your TIN. Certain penalties may also apply.

WHAT NAME AND NUMBER TO PROVIDE ON THIS FORM

INDIVIDUALS: Provide the name shown on your Social Security card.
NAME CHANGE: If the Social Security Administration has not been informed of your name change, please enter your name as shown on your Social Security card, then write your new full name.
SOLE PROPRIETOR: Enter your INDIVIDUAL name and either your Social Security Number (SSN) or Employer's Identification Number (EIN). You may also enter your business name.
CUSTODIAN ACCOUNT OF A MINOR (UNIFORM GIFT TO MINORS ACT) - Enter the minor's name and SSN.
THE USUAL REVOCABLE SAVINGS TRUST (Grantor is also Trustee) - Give the name of the Grantor-Trustee and their SSN.
A PENSION TRUST OR OTHER VALID TRUST - List the name and EIN of pension trust or other Legal trust. Do NOT furnish the TIN of the Trustee, unless the legal entity itself is not designated in the account title.
CORPORATION - Give name of Corporation and EIN of Corporation.
PARTNERSHIP - Give name of partnership and Employer's Identification Number.
JOINT OWNERSHIP (TWO OR MORE INDIVIDUALS) - Give the name and SSN of the FIRST individual listed on the application as policyowner.

IF YOU DON'T HAVE A TAX I.D. NUMBER

You must apply for a Tax I.D. number immediately. To apply, get FORM SS-5, Application for a Social Security Card (for individuals), from your local office of the Social Security Administration, or FORM SS-4, Application for Employer Identification Number (for businesses and all other entities), from your local IRS office.

To complete Form W-9, write "Applied For" on the front then sign and date the form and return it to your agent. This means that you have already applied for a TIN OR that you intend to apply for one in the near future. As soon as you receive your TIN, complete another Form W-9, include your new TIN, sign and date the form and send it to The Lafayette Life Insurance Company. If not received, backup withholding will begin, when applicable, and continue until you furnish your TIN. Payees exempt from backup withholding and for which no information reporting is required are: (1) a Corporation, (2) an organization exempt from tax under Section 501(a), or an IRA, or a custodial account under Section 403(b)(7), (3) a United States government agency, or (4) a State or local government agency.

Lafayette Life Insurance Company

Illustration Certification Form

Proposed Insured's Name ______________________ Application/Policy Number ______________

- Check Part A if an illustration was not used during the Application Process.
- Check Part B if the application does not match the illustration.
- Check and complete Part C if a computer screen illustration was used AND no hard copy of the illustration was provided to the applicant.

CHECK ONLY ONE BOX

☐ PART A - No illustration used in the application process

The undersigned agent hereby certifies that an illustration was not used in connection with the application for insurance to The Lafayette Life Insurance Company submitted by the applicant. The undersigned applicant hereby acknowledges that no illustration was used in connection with the application for insurance. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

☐ 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 does not conform to the policy as applied for. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

☐ PART C - Computer Screen Illustration used, no hard copy furnished to applicant

AGENT: By signing below, I certify that I displayed a computer screen illustration 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 ____ Unisex
2. Underwriting or Rating Class ______________
3. Initial Death Benefit $ ______________
4. Age: ________
5. Generic Name of Policy ______________
6. Riders illustrated ______________________
7. Dividend Option: ______________
8. Number of policy years illustrated: ________
9. Premium Amount illustrated: $ __________
10. Guaranteed Interest Rates: ____________
11. Non-Guaranteed Interest Rates: __________
12. Assumed Number of Years of Premium: ________

APPLICANT: By signing below, I acknowledge that I viewed a computer screen illustration as stated above. No hard copy of the illustration was furnished. I further understand that an illustration conforming to the policy as issued will be provided to me no later than at policy delivery.

An illustration conforming to the policy as issued must be prepared and delivered to the applicant at or prior to delivery of the policy.

_____________ ______________________ ______________________

Date Agent's Signature Applicant's (Policyowner) Signature

______________________ ______________________

Agent's Name (Please Print) /License Number (where required) Applicant's Name (please print)

1 copy for Applicant, 1 copy for Agent, 1 copy for Home Office

Form 1772 02/07 W

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
Individual Product Operations: 1-800-243-6631 ext 3751 • Fax: 1-765-477-3298

Lafayette Life Insurance Company

Illustration Certification Form

Proposed Insured's Name ______________________ Application/Policy Number ______________

- Check Part A if an illustration was not used during the Application Process.
- Check Part B if the application does not match the illustration.
- Check and complete Part C if a computer screen illustration was used AND no hard copy of the illustration was provided to the applicant.

CHECK ONLY ONE BOX

☐ PART A - No illustration used in the application process

The undersigned agent hereby certifies that an illustration was not used in connection with the application for insurance to The Lafayette Life Insurance Company submitted by the applicant. The undersigned applicant hereby acknowledges that no illustration was used in connection with the application for insurance. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

☐ 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 does not conform to the policy as applied for. The applicant further acknowledges his or her understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

☐ PART C - Computer Screen Illustration used, no hard copy furnished to applicant

AGENT: By signing below, I certify that I displayed a computer screen illustration 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 _____ Unisex
2. Underwriting or Rating Class ______________
3. Initial Death Benefit $ ______________
4. Age: ________
5. Generic Name of Policy ______________
6. Riders illustrated ______________
7. Dividend Option: ______________
8. Number of policy years illustrated: ______________
9. Premium Amount illustrated: $ ______________
10. Guaranteed Interest Rates: ______________
11. Non-Guaranteed Interest Rates: ______________
12. Assumed Number of Years of Premium: ______________

APPLICANT: By signing below, I acknowledge that I viewed a computer screen illustration as stated above. No hard copy of the illustration was furnished. I further understand that an illustration conforming to the policy as issued will be provided to me no later than at policy delivery.

An illustration conforming to the policy as issued must be prepared and delivered to the applicant at or prior to delivery of the policy.

______________ ______________________ ______________________
Date Agent's Signature Applicant's (Policyowner) Signature

______________________ ______________________
Agent's Name (Please Print) /License Number (where required) Applicant's Name (please print)

1 copy for Applicant, 1 copy for Agent, 1 copy for Home Office

Form 1772 02/07 W

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
Individual Product Operations: 1-800-243-6631 ext 3751 • Fax: 1-765-477-3298

PREAUTHORIZED WITHDRAWAL

I authorize The Lafayette Life Insurance Company to initiate electronic fund transfer debits ("EFT debits") or to draw checks or drafts each month on the account at the bank or credit union named on the sample void check attached in the amount indicated to pay the premium, repay a loan or carry out the other purpose stated herein in connection with the below numbered policy or policies issued by the respective company. The issuing company is authorized to initiate EFT debits or to draw such checks or drafts in the necessary amount as provided in the policy, including the authority to increase the amount of the EFT debit or check if the policy provides for an increase in premium in the future.

A SAMPLE VOID CHECK OR SAMPLE VOID DRAFT MUST ACCOMPANY THIS FORM

(Please no deposit slips)

I hereby request and authorize my bank and/or credit union to honor and charge to my account EFT debits and checks or drafts drawn on my account for the purposes stated above and made payable to The Lafayette Life Insurance Company for banking purposes. The signature on such checks or drafts may be either typed or printed.

This authorization does not modify or change the provisions of the policy or policies to which this authorization applies except any right of the owner(s) to receive a notice of payment due which is expressly waived. Neither the authorization or its use shall modify the provisions of the policy or policies with respect to nonpayment of any premium or days of grace.

The privilege of making payments by Preauthorized Withdrawal may be revoked if any EFT debit, check, or draft is not paid upon presentation.

If the authorization is later cancelled, payment must be paid quarterly, semiannually, or annually. If more than one policy is to be paid under this authorization, the Company may combine the monthly payments in one EFT debit, check, or draft.

Policy or Application Number	Name of Insured	Premium Amount $10.00 Minimum	Other	Type of Account
				☐ Checking
				☐ Savings

Withdraw payment on the ______ day (1st - 28th) of each month starting ______________ .

NOTE TO AGENT: UNLESS REQUESTED OTHERWISE, FOR NEWLY ISSUED POLICIES THE WITHDRAWAL DATE 1. WILL BE THE SAME DAY AS THE POLICY ISSUE DAY (FOR A NEW MONTHLY WITHDRAWAL) OR 2. ADDED TO AN EXISTING MONTHLY WITHDRAWAL IF REQUESTED (UNIVERSAL LIFE POLICIES WITHOUT A ROLLOVER PAYMENT ***CAN-NOT*** BE DRAWN AFTER THE POLICY ISSUE DAY).

I request the company to withdraw the initial payment(s)* ________________ (initials of depositor)
*Insurance is not effective until initial payment is honored by depositors bank

Bank | Please PRINT Name of Depositor's Account | Depositor Account Number

Bank Address | City / State / Zip

Signature of Depositor and Signature of Joint Depositor (Joint Depositor Must Sign) | Signature of Policyowner (If Other Than Depositor) | Date

Form 1004 02/07 W

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
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