



Application for Life Insurance



**Lafayette
Life**
Insurance Company

1905 Teal Road
P.O. Box 7007
Lafayette, Indiana 47903
800-243-6631 • FAX: 765-477-3349
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.

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))

Table with columns: Spouse / Payor / SPO Full Name, Sex, Birth Date, Birth State, Age, Insurance in Force, Height / Weight, Occupation / Duties, Employer Name & Address, Years Employed. Includes rows for Child(ren) with columns: 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 \$ 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:

Table with columns: 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 in force \$

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	
	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you or any other person proposed for insurance in the past five (5) years: 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 signed for the purpose of collecting information in connection with an application for an insurance policy will be valid for a period of thirty (30) months from the date the authorization is signed. Authorization signed for the purpose of collecting information in connection with a claim for benefits under a life insurance policy will be valid from the date signed below for the duration of the claim. Authorization signed for accident or sickness insurance will be valid for the term of coverage of the policy. I (We) elect to be interviewed if an investigative consumer report is prepared in connection with the application for insurance. Upon my (our) request, I (we) are entitled to receive a copy of such investigative consumer report.

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.

Any person who knowingly and with intent to defraud an insurer submits an application for insurance or files a claim containing false or deceptive statements may have violated state law.

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. The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

\$ _____ 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.
(Must Always Be Answered)

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

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 # _____ Agent's Name _____
(if required) 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 The 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**



**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 The 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**



NOTICE AND CONSENT TO TESTING OF BLOOD OR OTHER BODILY FLUID FOR HIV ANTIBODY

HIV ANTIBODY TEST:

To determine your insurability, the insurer named above (hereafter referred to as the "Insurer") has requested that you provide a sample of your blood or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

One of the tests to be performed on this sample may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV) also known as the AIDS (Acquired Immunodeficiency Syndrome) virus.* This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation. The HIV test is actually a series of tests done through a medically accepted procedure.

*For a description of the other tests which may be performed, please refer to the Authorization for Testing of Blood or other bodily fluid and Disclosure of Test Results.

DISCLOSURE OF TEST RESULTS:

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. A copy of the test results may be maintained by the Insurer in the applicant's insurance file. When necessary for business reasons in connection with the insurance you have or have applied for with the Insurer, the Insurer may disclose test results to and permit access to your insurance file by others such as its affiliates, reinsurers, employees, or contractors. If you request, in writing, that we provide you with the names of specific organizations or individuals who may have access to your test results and your insurance file, we will supply you with this information.

If the test results are abnormal (positive), the Insurer will report to the Medical Information Bureau, Inc. (M.I.B., Inc.) a generic code which signifies only a non-specific blood or bodily fluid test abnormality. If your HIV antibody test is normal or indeterminate, no report will be made about it to the M.I.B., Inc. The fact that the test has been done and the results of the test will not otherwise be disclosed except as permitted by law or authorized you.

NEGATIVE HIV ANTIBODY TEST RESULTS:

Please check **ONLY ONE** of the following:

- I **DO NOT** wish to have my HIV test results disclosed to me if my test is **NEGATIVE**.
- Please notify me in writing at the address listed on my application if the results of my HIV antibody test are negative.
- Please submit written notification of negative test results to:

Name of Physician / Health Care Provider: _____

Address: _____

POSITIVE OR INDETERMINATE HIV ANTIBODY TEST RESULTS:

If the results are reported by the laboratory to the Insurer as positive or indeterminate, the Insurer will provide written notification of such result to the physician or other health care provider which you have designated below. If you so desire, you may request that we submit the results in writing directly to you. However, we urge you to supply the name of a physician or other health care provider who, in the event the results of your test are positive or indeterminate, can provide counseling as to the meaning of test results and can make appropriate referrals.

Please check ONLY ONE of the following:

- Please submit written notification of positive or indeterminate test results to:

Name of Physician / Health Care Provider: _____

Address: _____

- Please submit written notification of positive or indeterminate test results directly to me at the address listed on my application.

Should you choose to have written notification of positive or indeterminate test results submitted directly to you, please be advised that you may obtain personal, face to face counseling through the Virginia Department of Health. To obtain information about counseling, you should contact your local health department. For additional information about AIDS or HIV infection, you may call the Virginia Health Department at 1-800-533-4148.

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

CONSENT TO TESTING:

I have read and I understand this Notice and Consent to Testing of Blood or Other Bodily Fluid for HIV Antibody. I voluntarily consent to the withdrawal of blood or other bodily fluid, the testing of that blood or bodily fluid, and the disclosure of test results as described above.

A photocopy of this form shall be as valid as the original.

Date

Printed name of Proposed Insured

Proposed Insured's Date of Birth

Signature of Proposed Insured or Parent / Guardian

State of Residence of Proposed Insured

Witness (Agent, if present)

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

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

1. ANNUAL INCOME

Earned	Unearned
\$ <input type="text"/>	\$ <input type="text"/>
Total Assets	Total Liabilities
\$ <input type="text"/>	\$ <input type="text"/>
Net Worth	
\$ <input type="text"/>	

2. How much insurance does spouse have? \$

3. Has any person or business applicant ever filed for bankruptcy?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

4. Are the other owners, partners, officers or key personnel insured?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

5. Any other business insurance in force on the proposed Insured?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

Amount \$

Name of Business	Date Organized	Net Annual Income (Last Year)	Net Worth (Approximate)	
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Name/Title	% Owned	Value of Business Interest	Salary	Amount Carried or Applied - For
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
Paramedical & Urine Specimen	<input type="checkbox"/>	<input type="checkbox"/>
Blood Profile with Urine Specimen	<input type="checkbox"/>	<input type="checkbox"/>
Resting EKG	<input type="checkbox"/>	<input type="checkbox"/>
Treadmill EKG	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>
2nd Examination & Urine (if necessary)	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does any child to be covered appear to have any disease or impairment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are all eligible children being insured?	<input type="checkbox"/>	<input type="checkbox"/>
4. Amount of coverage on each parent?		
Mother	\$ <input type="text"/>	
Father	\$ <input type="text"/>	

Credit this application to

<input type="text"/>	%	Code	<input type="text"/>
<input type="text"/>	%	No.	<input type="text"/>

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)	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the proposed Insured read or speak English? a. If no, did you ask the questions in his/her language?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you related to the proposed Insured? (If yes, how? _____)	<input type="checkbox"/>	<input type="checkbox"/>
4. Was this application taken in person? (If no, please explain in Remarks Section)	<input type="checkbox"/>	<input type="checkbox"/>
5. If this policy will not be delivered in the application state, please indicate the state where delivery will take place:	<input type="text"/>	
6. How long have you known the proposed Insured? (applicant, if the proposed Insured is under age 15)	<input type="text"/>	



**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

- 1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES NO
- 2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? YES NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1			
2			
3			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales materials used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature

Printed Name

Date

Producer's Signature

Printed Name

Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Can they change?

You're older--are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?



**AGENT STATEMENT
WHEN REPLACEMENT IS INVOLVED**

Application For: _____

In connection with this replacement transaction, I hereby state that the following sales material was used with the applicant. (Identify any preprinted or electronically presented insurer approved sales material used.)

Insurer-Approved Sales Materials (Please list) _____

I have also submitted to the Company copies of any individualized sales materials used, including any illustrations for the policy. "Sales material" means a sales illustration and any other written, printed or electronically presented information created, completed or provided by the company or producer that is used in the presentation to the policy or contract owner and which describes the benefits, features and costs of the specific policy or contract which is purchased.

A copy of all sales material used **MUST** be left with the applicant.

POLICY REPLACEMENTS:
Lafayette Life adheres to ACLI's Principles and Code of Ethical Market Conduct. For replacement the Code states, "Distributors do not replace existing life insurance policies and annuity contracts without first communicating to the customer information that he or she needs in order to ascertain whether such replacement of existing policies or contracts may or may not be in his or her best interest."

While policy replacement may not be in the consumer's best interest, there may be circumstances where it is appropriate for a client to consider replacement. The Lafayette Life Insurance Company is interested in the sale of new insurance but not at the expense of existing insurance. We condemn the indiscriminate use of replacement to sell insurance.

I hereby represent that this replacement is appropriate and in accordance with The Lafayette Life Insurance Company's position regarding the acceptability of replacements.

Date

Agent's Signature

THIS FORM MUST ACCOMPANY SIGNED REPLACEMENT FORMS AND BE SENT WITH THE APPLICATION TO THE HOME OFFICE AT THE ADDRESS SHOWN ABOVE.



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 insane or during commission of a felony. Lafayette Life's sole obligation in such a case will be to return the sum received 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

R. J. Vargo
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.



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
				<input type="checkbox"/> Checking <input type="checkbox"/> 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 _____