GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Application for Individual Life Insurance

Upon approval of this application, the policy will be delivered to:
❒ Insured ❒ Owner ❒ Agent

Part A: Proposed insured (Full legal name)

Full name of applicant: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Gender

Address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Phone number | Mobile phone number | Email address | Social Security number

Have you used tobacco in any form, electronic cigarettes, or other nicotine products in the past 12 months? ❒ Yes ❒ No

Part B: Owner (Complete only if other than proposed insured)

Full name of owner: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Gender

Address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Phone number | Email address | Relationship to insured | Social Security number

Part C: Medical information

For purposes of these questions, "you" means the proposed insured.

1. Are you currently or have you been advised in the past **3 months** by a licensed member of the medical profession to be hospitalized, confined to a nursing facility, receiving home health care, or in hospice? ❒ Yes ❒ No
2. Do you require assistance from anyone with the following activities of daily living: taking medications, bathing, dressing, eating, toileting, transferring from a chair or bed, moving about, or are you confined to a bed? ❒ Yes ❒ No
3. Do you require use of an electric scooter or are you confined to a wheelchair as advised by a licensed member of the medical profession due to a chronic medical condition or illness? ❒ Yes ❒ No
4. Do you require the use of oxygen or oxygen equipment to assist with breathing? ❒ Yes ❒ No
5. Do you currently have or are you being treated by a licensed member of the medical profession for any form of cancer (excluding basal cell skin cancer) **or** have you been treated for a recurrence of a previous cancer or metastatic cancer (cancer that has spread to other parts of the body)? ❒ Yes ❒ No
6. In the past **24 months** have you been diagnosed, treated, tested positive, given medical advice, recommended to have treatment, or prescribed medication by a licensed member of the medical profession for:
   - ❒ Alzheimer's disease, dementia, or organic brain disorder;
   - ❒ terminal illness that is expected to result in death within the next 12 months;
   - ❒ amyotrophic lateral sclerosis (ALS);
   - ❒ congestive heart failure or cardiomyopathy;
   - ❒ amputation due to disease;
   - ❒ sickle cell anemia;
   - ❒ respiratory failure, cystic fibrosis, or pulmonary fibrosis;
   - ❒ kidney failure, chronic kidney disease, or kidney dialysis;
   - ❒ cirrhosis of the liver, liver failure, or any other chronic liver disease;
   - ❒ organ or bone marrow transplant;
   - ❒ diabetes with complications or in combination with a prior diagnosis of: stroke/TIA, heart disease or disorder, neuropathy, kidney disease, any circulatory disease that affects the heart and/or blood vessels, diabetic coma, or insulin shock? ❒ Yes ❒ No
7. Were you diagnosed by a licensed member of the medical profession with diabetes prior to age 30? ❒ Yes ❒ No
8. Have you been treated for or diagnosed by a licensed member or the medical profession with acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or tested positive for human immunodeficiency virus (HIV)? ❒ Yes ❒ No
9. Within the past **12 months** have you had any treatment, diagnostic testing, surgery, or hospitalization recommended by a medical professional which have not been completed or for which the results have not been received? ❒ Yes ❒ No

Part C: Medical information (continued)

10. Within the past **12 months** have you had any unexplained weight gain or loss greater than 10 pounds? ❒ Yes ❒ No

If any of questions 1 through 10 are answered "Yes," the proposed insured should apply for the Guaranteed Assurance plan.

11. In the past **36 months** have you been diagnosed, treated, tested positive, given medical advice, recommended to have treatment, or prescribed medication by a licensed member of the medical profession for:
    - ❒ neuromuscular disease, Parkinson's disease, or multiple sclerosis;
    - ❒ internal cancer (excluding basal cell skin cancers), malignant melanoma, leukemia, Hodgkin's disease, myeloma, or lymphoma? ❒ Yes ❒ No

12. In the past **24 months** have you been diagnosed, treated, tested positive, given medical advice, or prescribed medication by a licensed member of the medical profession for:
    - ❒ angina;
    - ❒ systemic lupus;
    - ❒ drug or alcohol abuse, dependency, or addiction, illegal drug use or misused prescription drugs;
    - ❒ hepatitis B, C, or chronic hepatitis;
    - ❒ chronic pulmonary disease, emphysema, chronic obstructive pulmonary disease (COPD), or chronic bronchitis or required the use of oxygen or oxygen equipment? ❒ Yes ❒ No

13. In the past **24 months**, have you been diagnosed, treated, had surgery, or has treatment or surgery been recommended by a licensed member of the medical profession for:
    - ❒ heart attack;
    - ❒ embolism or blood clot;
    - ❒ stroke or TIA (mini stroke);
    - ❒ irregular heart rhythm;
    - ❒ seizures;
    - ❒ aneurysm;
    - ❒ heart, brain, or circulatory surgery, including:
        - ❒ pacemaker or defibrillator placement;
        - ❒ cardioversion;
        - ❒ stent placement;
        - ❒ bypass;
        - ❒ angioplasty;
        - ❒ ablation;
        - ❒ valve replacement or repair? ❒ Yes ❒ No

If any of questions 11 through 13 are answered "Yes," the proposed insured should apply for the Graded Death Benefit plan.

All medical questions 1 through 13 need to be answered "No" to qualify for the Great Assurance plan.

Primary care physician

Note: In order to qualify for the Great Assurance or Graded Death Benefit plans a primary care physician's name and number is needed.

Name of physician _____ Office phone number _____

Part D: Policy information

❒ Great Assurance Final Expense ❒ Graded Death Benefit ❒ Guaranteed Assurance

Face amount: $_____ Requested effective date (MM/DD/YYYY):_____

Payment method: ❒ Bank draft ❒ Credit card

Payment frequency: ❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually

Base Premium Amount: $_____

Optional benefit riders:

❒ Dependent Child/Grandchild Rider *(complete separate application)* Rider Premium Amount: $_____

❒ Accidental Death Rider *(only available with Great Assurance Final Expense)*
Are you a member of the United States military, military reserves or the National Guard? ❒ Yes ❒ No Rider Premium Amount: $_____

Total Premium Amount: $_____

Adjustments to Coverage and Premiums. The plans available through this application are, in order of highest to lowest immediate coverage, Great Assurance Final Expense, Graded Death Benefit, and Guaranteed Assurance. The owner ("you") agrees that you are applying for the plan with the highest immediate benefit and rate class for which you are eligible, beginning with the plan selected above. Eligibility is based on information in this application

Part D: Policy information (continued)

or obtained by the Company (defined below) during the underwriting process. The plan or face amount approved may be less than what is selected above and not all riders are available on all plans. If you are not eligible for the plan or rate class selected above, then, based on your election below, the Company will either adjust the face amount to match the premium listed above or adjust the premium to match the face amount listed above, subject to the Company's current rates, rate classes, and plan rules. If necessary, the premium may increase or decrease from what is listed above to meet the issued plan's rules.

- ❒ Adjust the face amount to match the premium.
- ❒ Adjust the premium to match the face amount.

Part E: Beneficiary

Primary (*full legal name)*		Date of birth (MM/DD/YYYY)	
Address	City	State	ZIP code
Relationship to insured	Phone number	Social Security number	
Contingent (*full legal name)*		Date of birth (MM/DD/YYYY)	
Address	City	State	ZIP code
Relationship to insured	Phone number	Social Security number	

Part F: Application agreement

By signing below, I (both the owner and proposed insured) agree: (1) I represent statements in this application are complete and true. (2) When the policy is delivered, the proposed insured must be alive and in the same health as described above or there will be no insurance. (3) No insurance exists unless and until coverage is approved by Great Western Insurance Company, the first premium is paid, and a policy is delivered.

Authorization: I, the proposed insured, authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan or any other entity that possesses any diagnosis, treatment, prescription or other medical information about me to furnish such health information to Great Western Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company") and their agents and representatives for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or its reinsurers to make a brief report of my personal health information to the MIB.

I affirm that no illustration was used in the sale of this product.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy or the policy itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Great Western Insurance Company, P.O. Box 14410, Des Moines, Iowa 50306-3410.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.

Part F: Application agreement (continued)

- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.
- I agree that a copy of this Authorization is as valid as the original.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Do you have any existing insurance policies or annuity contracts? ❒ Yes ❒ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? *If "Yes," complete required replacement form(s).* ❒ Yes ❒ No

X _____

Proposed insured's signature Date *(MM/DD/YYYY)*

❒ Please check if you are signing as a POA or guardian and provide the proper documentation.

X _____

Owner's signature *(if other than proposed insured)* Date *(MM/DD/YYYY)*

Part G: Agent certification

I certify that the answers from the proposed insured to Part C were recorded accurately.

Does the applicant have any existing insurance policies or annuity contracts? ❒ Yes ❒ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? ❒ Yes ❒ No

Agent Full Name *(Please print)* Agent number

X _____

Agent's signature Date *(MM/DD/YYYY)*