Application for Group Life Insurance for Great Western Preneed Plans Trust to GREAT WESTERN INSURANCE COMPANY

3434 Washington Blvd. Ste. 100 • Ogden, Utah 84401 • (800) 621-5688 *(Please Print)*

☐ State Print Agent Name _____ Agent Number ☐☐☐☐ - ☐☐ Date (mm/dd/yyyy) _____

Insured's Information

Full Name

Social Security # | Sex

Birthdate (M/D/YYYY) | Age

Mailing Address

City

State | Zip

Telephone #

Owner (if other than insured)

Full Name

Relationship

Social Security # | Sex

Address

City, State, Zip

Telephone #

Primary Care Physician

Complete only if applying for First-Day coverage.

Name

Address

Telephone # ( )

Certificate Information

Total	Face Amount $	Total Paid to Agent $
Base Plan	Face Amount $	Modal Premium $
Down Payment Rider–Optional	Face Amount $	Premium Amount $
Grandchild Rider (complete additional application)		Premium Amt $
Away-From-Home Supplement Rider		Premium Amt $

Payment Method ☐ Single ☐ 1 yr ☐ 3 yr ☐ 5 yr ☐ 10 yr ☐ Mo ☐ Qtr ☐ Semi ☐ Ann

☐ Coupon Sheet ☐ Automatic Bank Withdrawal ☐ Course ☐ Voyage

Special Instructions

Beneficiaries

Primary

Relationship

Social Security #

Address

Contingent

Relationship

Social Security #

Address

Please detach or lay flat to write on, or separate sides with manila folder or cardstock. Writing on folded form will cause marks on all pages.

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

Assignment

❑ Yes ❑ No Initial Approval _____

I hereby ***irrevocably assign*** and ***transfer*** all the benefits and proceeds of this certificate to _____ as their interest may appear. I understand fully the effects of this assignment and transfer. It is my intention as owner to continue to pay premiums and retain ownership.

Does the applicant have any existing policy or annuity? ❑ No or ❑ Yes

Will the proposed insurance replace any existing policy or annuity? ❑ No or ❑ Yes If yes, please complete a replacement form.

INSURED'S NAME _____

Multi-Pay Health Questions

	Yes	No	Initial
1. Now or within the last **two** years, has the insured been, or been told to be and refused to be, hospitalized or in a nursing facility?	☐	☐	_____
2. In the last two years, has the insured been diagnosed, treated, or prescribed drugs by a healthcare provider for any of the following diseases? Cancer, Tumor, Insulin-Dependent Diabetes, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Acquired Immune Deficiency Syndrome-RelatedComplex (ARC), any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System or Liver?	☐	☐	_____

I affirm that both the above health questions have been answered correctly. If either of the health questions is answered "yes," or is not answered, I will be issued a certificate with a two-year limited death benefit, per thousand dollars of face amount as outlined below:

Plan Type	1st-Yr Monthly Increases	12th Month Value	2nd-Yr Monthly Increases	24th Month Value	25th Month Value and thereafter	Initials
☐ 1-Yr	$94	$1,000	–	$1,000	$1,000	_____
☐ 3-yr	$41	$ 500	$41	$1,000	$1,000	_____
☐ 5-yr	$33	$ 400	$41	$ 900	$1,000	_____
☐ 10-yr	$25	$ 300	$33	$ 700	$1,000	_____

Agreement

By signing below, I agree that: (1) To the best of my knowledge and belief, statements in this Application are complete and true. (2) When the certificate is delivered, the Insured must be alive and in the same health as described above or there will be no insurance. Also, the full premium for the chosen period must be paid by the time the certificate is delivered. (3) By accepting the certificate, I approve any change(s), correction(s), or addition(s) that Great Western made when issuing it. If my approval requires written consent, a form will be included.

Insurable Interest: If the owner is other than the insured, by signing below, the owner certifies that he/she has insurable interest in the life of the insured as defined by the state statute in which the policy is issued.

Authorization: By signing below, I approve of any healthcare provider, medical facility, or other person, including a Veterans Administration Hospital, giving the Great Western Insurance Company any records or information it needs about the Insured's health. A copy of this approval will be as effective as the original. This approval is only valid for 30 months. The Insured, or a person authorized to act on behalf of the Insured, is entitled to receive a copy of this authorization upon request. **I affirm that no illustration was used in the sale of this product.**

Signed at _____ , _____
City and State — Month Day Year

Insured _____
Parent or Guardian, If Juvenile Insured

Owner _____
If Other Than Insured

Agent _____ #_____
Replacement of insurance is involved. ☐ YES ☐ NO

To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of Great Western Insurance Company at the address listed above.

Authorization Agreement for Preauthorized Automatic Bank Withdrawals

Please Attach a Voided Check

Your Financial Institution's Name (DEPOSITORY)

Your Financial Institution's City and State

Your Transit (ABA) No. (The first nine numbers on the bottom of the check)

Your Account No. ☐ Checking Account **or** ☐ Savings Account

I hereby authorize **Great Western Insurance Company** (THE COMPANY) to initiate debit entries. If necessary, THE COMPANY may credit entries on the above named financial institution and account.

This authorization is to remain in full force and effect until THE COMPANY receives written notice of its termination. The notice must be in such time and in such manner as to allow THE COMPANY and DEPOSITORY reasonable time to act (minimum of three weeks).

Authorized Signature:

Authorized Name (please print)

Date	Withdrawal Date