Agent Number: _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Great Western Insurance Company
P.O. Box 9160 Ogden, Utah 84409-9160 • Fax: 801-689-1929 • Phone: 866-252-5594 • Email: fepolicies@gwic.com

A. Proposed Insured *(Full legal name)*

First Name	Middle Initial	Last Name	
Street Address	City	State	Zip Code
Phone Number	Date of Birth (mm / dd / yyyy)	Social Security Number	
Sex: ☐ Male ☐ Female	Email Address		

B. Owner *(Complete only if other than proposed Insured)*

First Name	Middle Initial	Last Name	
Street Address	City	State	Zip Code
Phone Number	Date of Birth (mm / dd / yyyy)	Social Security Number	
Sex: ☐ Male ☐ Female	Email Address	Relationship to Insured	

C. Health Questions

1) In the last two years, has the applicant been diagnosed as terminally ill, been in hospice, or been confined to or been advised to be confined to a hospital or nursing home for five or more days? ☐ Yes ☐ No

2) Is the applicant unable to independently perform routine activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? ☐ Yes ☐ No

3) In the last two years, has the applicant been diagnosed with, been prescribed medication for or treated by a healthcare provider for any of the following diseases: Cancer (other than basal cell carcinoma), Tumor, Insulin-Dependent Diabetes, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Acquired Immune Deficiency Syndrome-Related Complex (ARC), or any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System or Liver? *For Prescriptions: Please do not mark "Yes" if the prescription(s) is a maintenance medication and has remained the same (or the generic equivalent) at the same or at a decreased dosage for the past two years. For Treatment: Please do not mark "Yes" if your visit(s) with your healthcare provider in the last two years was a routine review of your maintenance medication and no additional treatment was given or diagnosis was made during your visit(s).* ☐ Yes ☐ No

If all of the health questions are answered "NO," the proposed Insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES" or are not answered, then the Policy will be issued with a Graded Death Benefit.

Primary Care Physician *(Required for Level Death Benefit)*	Phone Number

D. Policy Information

Face Amount: $	Ultimate Death Benefit: $ *For Level Death Benefit, multiple Face Amount by 125%*
Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	Base Premium Amount: $
☐ Dependent Child / Grandchild Rider *(complete separate application)* *$5,000 Face Amount on base Policy is required*	Rider Premium Amount: $ *($1.00 per month)*
	Total Premium Amount: $
Spousal Bonus Rider – Full Name and Date of Birth: *$10,000 Face Amount on each Policy is required*	

Proposed Insured's Last Name: _____

E. Beneficiary Information *(Use additional form for more beneficiaries)*

Primary *(Full legal name)*		Relationship	
Street Address	City	State	Zip Code
Contingent *(Full legal name)*		Relationship	
Street Address	City	State	Zip Code

F. Agreement

By signing below, I agree: (1) To the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Insured must be alive and in the same health as described or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the Policy is delivered. By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that have been made to the Policy for which I am applying.

Insurable Interest: I certify compliance with all of the insurable interest laws in force in the state of South Dakota.

Authorization: I authorize any healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the Insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to the Insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for twenty-four (24) months from the date signed. 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. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC. I affirm that no illustration was used in the sale of this product.

FRAUD WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fine and confinement in prison.

G. Privacy Policy

I agree to receive electronically all initial and annual privacy policy notices associated with this insurance policy. Notices will be sent to the email address provided above. ☐ Yes ☐ No _____ *Initial*

H. Signature Section

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? ☐ Yes ☐ No
If "Yes, complete required replacement form(s).

x _____ Signed on: _____ Signed on: _____
Proposed Insured's Signature (mm / dd / yyyy) (City, State)

x _____ Signed on: _____ Signed on: _____
Owner's Signature *(If other than Proposed Insured)* (mm / dd / yyyy) (City, State)

I. Agent Section

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 Signed on (mm / dd / yyyy)