Settlers Life
It's about people.
A Member of the NGL Insurance Group

SETTLERS LIFE INSURANCE COMPANY
Madison, Wisconsin
Administrative Office: P.O. Box 8600 • Bristol, Virginia 24203

Policy Number

Individual Whole Life Insurance Application

Faxed App: _____

www.settlerslife.com

Use this application for the Bronze, Silver and Gold life insurance plans.
Please complete sections per underwriting guide.

A. Proposed Insured

First, MI, Last Name, Maiden, Suffix: _____

Sex: ☐ Male ☐ Female DOB: _____ Backdate to Save Age: ☐ Yes ☐ No Birth State: _____

Birth Country: _____ SSN: _____ Email Address: _____

Residential Address: _____

Mailing Address: _____

Phone Number (Day) _____ Phone Number (Evening): _____ Best time to Call: _____

US Driver's License #or Other I.D. _____ State Issued: _____ Expiration Date: _____

Is an assignment of ownership being made to NGL Trust? ☐ No Yes (check one): ☐ FET ☐ EPT

B. Policy Owner (if other than Proposed Insured)

First, MI, Last Name, Suffix: _____

Mailing Address: _____

Phone Number : _____ Email Address: _____

Date of Birth: _____ SSN or TIN: _____ Relationship to Insured: _____

C. Policy Co-Owner (if any)

First, MI, Last Name, Suffix: _____

Mailing Address: _____

Phone Number : _____ Email Address: _____

Date of Birth: _____ SSN or TIN: _____ Relationship to Insured: _____

D. Beneficiary (if other than NGL Trust)

First, MI, Last Name, Suffix: _____

Residential Address: _____

Phone Number : _____ Email Address: _____

Date of Birth: _____ SSN or TIN: _____ Relationship to Insured: _____

E. Contingent Beneficiary (if other than NGL Trust)

First, MI, Last Name, Suffix: _____

Residential Address: _____

Phone Number : _____ Email Address: _____

Date of Birth: _____ SSN or TIN: _____ Relationship to Insured: _____

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F. Physician Information

Primary Physician's Name and Phone Number: _____

Physician's Address: _____

G. Health Questions for Bronze, Silver, Gold Plans

1. Is the Proposed Insured currently hospitalized, bedridden due to disease, confined to a nursing facility, or receiving hospice or home health care? ☐ YES ☐ NO
2. Has the Proposed Insured been diagnosed by a member of the medical profession with AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? ☐ YES ☐ NO

H. Health Questions for Silver, Gold Plans

1. Has the Proposed Insured used any form of tobacco in the past 12 months other than chewing tobacco or snuff? ☐ YES ☐ NO
2. Is the Proposed Insured currently required to receive personal assistance with activities of daily living such as bathing, dressing, eating, taking medications, toileting or moving about? ☐ YES ☐ NO
3. Has the Proposed Insured ever had or been recommended by a member of the medical profession to have an Organ Transplant? ☐ YES ☐ NO
4. In the past two years has the Proposed Insured been diagnosed by a member of the medical profession:
   - i. with diabetes requiring insulin, been prescribed or used insulin for the treatment of diabetes, or been diagnosed with or treated for complications of diabetes, including Insulin Shock, Diabetic Coma, Retinopathy, Neuropathy, Amputation, or Kidney disorder? ☐ YES ☐ NO
   - ii. as requiring or undergone surgery for Heart Disease (including heart bypass), Angioplasty, Stent Placement, Peripheral Vascular Disease, or Amputation due to disease? ☐ YES ☐ NO
   - iii. as requiring or been prescribed oxygen to assist with breathing? ☐ YES ☐ NO
5. In the past two years has the Proposed Insured been diagnosed by a member of the medical profession with, treated for or prescribed medication for: Angina, Coronary Artery Disease, Heart Attack, Congestive Heart Failure, Cardiomyopathy, Atrial Fibrillation, Chronic Asthma, Chronic Bronchitis, Black Lung, Cystic Fibrosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's, Dementia, Progressive Memory Loss, Aneurysm, Multiple Sclerosis, Parkinson's Disease, Stroke, Systemic Lupus, Sickle Cell Anemia, Kidney Failure, Kidney Disease, Liver Disease, Hepatitis, or any form of cancer other than basal cell skin cancer? ☐ YES ☐ NO
6. In the past two years has the Proposed Insured used illegal drugs or marijuana, or received or been advised by a member of the medical profession to receive counseling or treatment for excessive use of alcohol or prescription drugs? ☐ YES ☐ NO
7. If the Proposed Insured is under the age of 25, has the Proposed Insured ever been diagnosed by a member of the medical profession with: Cerebral Palsy, Down Syndrome, Diabetes requiring insulin, Mental Retardation, Muscular Dystrophy or Spina Bifida? ☐ YES ☐ NO

I. Health Questions for Gold Plan

1. Please state the Proposed Insured's: Height _____ and Weight _____.
2. In the past five years has the Proposed Insured been diagnosed by a member of the medical profession as requiring or undergone surgery for Heart Disease (including heart bypass), Angioplasty, Stent Placement, Peripheral Vascular Disease, or Amputation due to disease? ☐ YES ☐ NO
3. In the past five years has the Proposed Insured been diagnosed by a member of the medical profession with, treated for or prescribed medication for: Angina, Coronary Artery Disease, Heart Attack, Congestive Heart Failure, Cardiomyopathy, Atrial Fibrillation, Chronic Asthma, Chronic Bronchitis, Black Lung, Cystic Fibrosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's, Dementia, Diabetes, Progressive Memory Loss, Bipolar Disorder, Schizophrenia, TIA (mini-strokes), Rheumatoid Arthiritis, Aneurysm, Multiple Sclerosis, Parkinson's Disease, Stroke, Systemic Lupus, Sickle Cell Anemia, Kidney Failure, Kidney Disease, Liver Disease, Hepatitis, or any form of cancer other than basal cell skin cancer? ☐ YES ☐ NO
4. In the past five years has the Proposed Insured used illegal drugs or marijuana, or received or been advised by a member of the medical profession to receive counseling or treatment for excessive use of alcohol or prescription drugs? ☐ YES ☐ NO
5. Has the Proposed Insured ever been diagnosed by a member of the medical profession with: Cerebral Palsy, Down Syndrome, Mental Retardation, Muscular Dystrophy or Spina Bifida? ☐ YES ☐ NO

J. Applicant Replacement Questions (If "Yes" complete required replacement forms.)

Does the Applicant have any existing life insurance policies or annuity contracts? ☐ YES ☐ NO

Will the insurance applied for replace, discontinue, or change any insurance or annuity now or recently in force? ☐ YES ☐ NO

K. Insurance Plans and Riders Applied For

☐	Bronze Plan (Modified Whole Life) Benefits reduced during first two years for death by natural causes	Ages 40 yr – 80 yr $1,000 - $15,000	Amount of Insurance: $_____ An Accelerated Benefit Rider will be issued with all Silver and Gold policies at no additional cost if the face amount of the base policy is $5,000 or more. This Rider is not available on policies with face amounts less than $5,000. A Child/Grandchild benefit (at the lesser of the base policy face or $5,000) will be included within all Silver and Gold policies.
☐	Silver Plan (Immediate Benefit Whole Life)	Ages 6 mo – 85 yr $1,000-$25,000 (6 mo-65 yr) $1,000-$20,000 (66 yr-75 yr) $1,000-$15,000 (76 yr-85 yr)	
☐	Gold Plan (Immediate Benefit Whole Life)	Ages 15 days – 85 yr $2,500 - $50,000 (15 days-80yr) $2,500 - $20,000 (81yr-85yr)	
☐	Accidental Death Benefit Rider (As defined in the policy, full benefits may be paid for accidental death)	Max. Eligible Age: 70 yr Max. Coverage: $100,000	Amount of Accidental Death Benefit Insurance $ _____

L. Premium Billing (Please answer all six items)

1. Premium Duration: ☐Life-Pay ☐20-Year ☐10-Year ☐Single-Pay

2. Premium Method: ☐PAC (Collect 1st premium) ☐Direct Bill
☐PAC (Draft 1st premium) ☐1035 Exchange
~~☐Direct Express~~ ☐List Bill

3. Premium Mode: ☐Monthly ☐Quarterly ☐Semi-Annual ☐Annual

4. Bill Day: ☐ No preference ☐ Match Existing
☐ Day of month ____ (1st – 28th)
~~☐ On the ____ (1st – 4th) _____ (Mon – Fri) of each month~~

Direct Express and Variable Billing not currently available.

5. Modal Premium Amount..$_____
(Add premium for Accidental Death Benefit Rider)

6. Premium Collected.....$_____

Where premium not submitted with application: If selected Bill Day is no more than 7 days prior to application approval and not in the previous month, the policy will bill immediately upon approval. Otherwise, the policy will first bill on the upcoming Bill Day.

M. Applicant's Statement

Fraud Warning Statement: 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.

I have read or had read to me the application and fraud warning statement. All the information is true and complete to the best of my knowledge and belief. The statements and answers in this application are the basis for any policy issues. No information will be considered to have been given unless it is on this application. The agent does not have the authority to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the application or policy. I acknowledge that the "Notice of Insurance Information Practices", the "Protected Health Information Authorization", the "MIB, Inc. Disclosure Notification", and the "Prescription History Authorization" were read by me or to me. I specifically endorse the "Protected Health Information Authorization" and the "Prescription History Authorization". The policy will not take effect until all eligibility requirements have been met and not until the effective date stated in the policy, and only if the policy is issued during the lifetime of the Proposed Insured. If I am the Owner for insurance on the life of the Proposed Insured, I certify that I have insurable interest in his or her life.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Owner (If Other than Proposed Insured) Date

_____ _____
Signature of Co-Owner (If Other than Proposed Insured) Date

Application Signed At: _____ _____
City State

N. Agent's Statement

Does the Applicant have any existing life insurance policies or annuity contracts?..... **Match Section J** ..... ☐ YES ☐ NO

Will the insurance applied for replace, discontinue, or change any insurance or annuity now or recently in force?..... ☐ YES ☐ NO

Are you related to the Applicant? If Yes, indicate relationship. ☐ No ☐ Yes _____

Was a telephone interview conducted? ☐ NO ☐ POS ☐ EPOS Date and time completed: _____

I certify that any information recorded by me on this application is true and accurate to the best of my knowledge.

_____ _____ _____ _____
Agent's Name-Please Print Signature of Agent Agent Number Date

FOR AGENT TRAINING ONLY

O. Agent's Remarks

P. Policy Payor

Check here if Policy Payor is: ☐ Proposed Insured ☐ Owner ☐ Other (If other, complete the following)

First, MI, Last Name, Suffix: _____

Mailing Address: _____

Phone Number : _____ Email Address: _____

Date of Birth: _____ SSN or TIN: _____ Relationship to Insured: _____

Q. Premium Withdrawal Authorization

Accountholder Name: _____

Financial Institution Name, City, and State: _____

☐ Checking ☐ Savings ~~☐ Direct Express~~

__ __ __ __ __ __ __ __ __

Routing # (lower left corner of check)

__ __

Bank Account # (middle of check)

~~__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __~~ ~~__ __/__ __ __ __~~

~~Direct Express Card Account Number~~ ~~Expiration Date~~

Direct Express is not currently available.

I authorize Settlers Life Insurance Company to make automatic withdrawals from my bank account or Direct Express account, as identified above, for premiums according to the amount, mode, duration, and timing set forth in the life insurance application to which this authorization is attached. I acknowledge that the actual date of withdrawal can vary due to holidays, weekends and is dependent on my Financial Institution. In the event a withdrawal is not honored, Settlers Life has the right to resubmit the transaction. I agree Settlers Life shall not be responsible for any charges for submitting an account withdrawal request consistent with this authorization. In the event a withdrawal is not paid upon presentation and any premiums due are not paid within the time stated in the policy, I acknowledge that the policy and its coverage may lapse or be terminated by Settlers Life Insurance Company. I agree that this authorization shall remain in effect until Settlers Life shall have received five (5) business days advance written notice of revocation from me. If the above identified account is replaced by another account or with an account from a different bank, this authorization shall apply to the successor account or bank.

Printed Name: _____

Accountholder Signature: _____ Date: _____