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 a patient in hospice, a hospital, or a 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," then 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: $
	Total Premium Amount: $

Spousal Bonus Rider – Full Name and Date of Birth:
$10,000 Face Amount on each Policy is required

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 in which this Policy will be issued.

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 presents a false statement in an application for insurance may be guilty of a criminal offence and subject to penalties under state law.

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)

CHILD / GRANDCHILD PROTECTION PLAN

Great Western Insurance Company • Mail policies to: P.O. Box 9160 Ogden, Utah 84401-9160
• Email: fepolicies@gwic.com • Phone: 866-252-5594 • Fax: 801-689-1929

State _____ Print Agent Name _____ Agent Number _____ Date _____

Insured's Information

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

Child / Grandchild Protection Rider Information

Existing Policy #	Rider Premium $1.00 per month

Does the applicant have any existing policy or annuity? ☐YES ☐NO

Will the proposed insurance replace any existing policy or annuity? ☐YES ☐NO

If "yes," please complete a replacement form.

Conditions of Child / Grandchild Protection Plan

I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.

- The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married.
- The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years.
- The Covered Child / Grandchild dies while the Insured on the base Policy is alive.
- The coverage under the base Policy to which this Policy is attached is active and current in its premium payments.

Child / Grandchild's Full Name	Date of Birth	Child / Grandchild's Full Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Agreement

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 Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) 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 GWIC may make to the Policy for which I am applying.

X_____ Signed on: _____ Signed at: _____
Insured's Signature *(mm/dd/yyyy)* (City, State)

X_____ X_____
Owner's Signature (*If other than the Proposed Insured)* Agent Signature

For the Agent: Is replacement of insurance 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 the Great Western Insurance Company at the address listed above.

Great Western Insurance Company

P.O. Box 3428 • Ogden, UT 84409-1428 • (800) 621-5688 • Fax (801) 689-1391

NOTICE

A. Explanation

Whether it is to your advantage to replace or change your existing insurance or annuity program, only you can decide. It is in your best interest to obtain adequate information in order to compare relative short and long range costs and benefits before a final decision is made.

The agent or insurance company assisting you with this new purchase must notify your existing agent or company so that they may prepare a detailed, current statement concerning your existing program for your comparison.

B. Existing Insurance Which May Be Replaced or Changed

Full Name of Insurance Company and Home Office Location	*Policy/Contract No.**	*Insured*

** If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.*

C. Items to Consider

1. Due to a possible change in insurability status (health, occupation or high risk recreational activities), you might be denied new coverage, or the premium may be higher than a standard premium.
2. The Incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your current insurance company may be able to modify your existing plan on terms which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. ***REMEMBER:*** Following receipt of a new life insurance policy or annuity contract, you should immediately examine its contents. If you are ***not satisfied*** with it for ***any*** reason, you have the right to return it within the twenty (20) day "examination period" to the insurer at the home office or branch office, or to the agent through whom it was purchased, for a full refund of the premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

Did you read the "Items to Consider?"

Applicant's Signature Date	Agent's Signature Date
Applicant's Name (Please Print)	Agent's Name and License Number (Please Print)
Address	Address
City, State, Zip Code	City, State, Zip Code
Telephone Number	Telephone Number

Premium Authorization Withdrawal Form

(Complete one form per Applicant)

Great Western Insurance Company
Mail policies to: PO Box 9160 Ogden, UT 84409-9160 • Phone: 866-252-5594
Fax policies to: 801-689-1929 • Email: fepolicies@gwic.com

Proposed Insured *(Full legal name)*

First Name	Middle Initial	Last Name

Payor Information

☐ Insured ☐ Owner ☐ Other Relationship: _____

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

Bank Account Information

Financial Institution (Bank Name):

☐ Checking ☐ Savings *Contact your bank to verify EFT is allowed*

Routing Number (lower left corner of check)

Bank Account Number (lower middle of check)

Credit Card Information

Credit Card

Exp. Date

M	M	Y	Y

CVV

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

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). If I select a specific date for the first payment, I authorize the Company to withdraw on or after the specified date as indicated below.

First payment to be ☐ drafted immediately
☐ drafted on specific date: _____
☐ paid by check

Subsequent payments to be drafted ☐Mo ☐Qtr ☐Semi ☐Ann on ☐ a specific day _____ (1–28)
☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Amount of Premium: $

Accountholder / Cardholder's Name *(Please Print)* _____

Accountholder / Cardholder's Signature _____ Date _____

INFORMATION ON THE ACCELERATED DEATH BENEFIT RIDER

INCLUSION OF RIDER
If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER
Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the Insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION
Qualifying Medical Condition means either: 1) Terminal Illness - You are terminally ill. You are expected to die within 12 months or 2) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS
The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the Insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT
The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE
This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs such as Medicaid. Prior to electing to buy the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS
This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care, nursing home, or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION
When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.