Application for Child Rider

United Farm Family Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

Application is hereby made for Child Rider to be provided by supplementary provision or agreement attached to and made part of:

Life Policy issued on: _____ (hereinafter referred to as Insured)

(Print Name of Insured)

with an Application date of: _____

1. Full name of children of Insured, including legally adopted children and stepchildren, who are under age 19	Relationship to Insured	Date of Birth*	Place of Birth (State or Country)	Ht.	Wt.	Social Security Number

***PLEASE NOTE: No coverage is afforded infants under 30 days.**

2. Child Rider Amount ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 *Total amount of Child Rider coverages cannot exceed $20,000*

	YES	NO
3. In the past 5 years has any child named in Question 1 had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any disease, ailment, injury or complaint which caused loss of time from school or work; any surgical operation, x-ray, electrocardiogram or other special tests, or been told there is a need for them?	☐	☐
4. In the past 10 years has any child named in answer to Question 1 had any deformity, impairment, abnormality or ailment of eyes, ears, arms, legs, brain, nervous system, heart, blood pressure, circulation, chest, lungs, digestion, kidneys, bladder or any other part of body, or been treated for a mental or nervous disorder?	☐	☐
5. Has any child named in answer to Question 1 been declined, postponed, limited, or had a policy issued other than as applied for on any life or health insurance or reinstatement thereof?	☐	☐
6. Is the insurance applied for intended to replace any existing insurance in this or any other company?	☐	☐

7. Give full details to questions requiring additional explanation.

Insured's Supplementary Statements and Certificate of Health

(Complete only if this is an addition to an existing policy)

1. Exact Height-Weight_____ Ft._____ In._____ Lbs. Has weight changed more than 10 lbs in past year? If yes, amount of increase_____ decrease_____	☐	☐
2. Since the date of the original application has the Insured had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	☐	☐

3. Name of physician Insured last consulted: _____

Address_____

Why consulted _____

Give name and address of family physician if different from above _____

4. Has Insured ever: Been exempted, or discharged as unfit, from military service; applied for or received any kind of disability compensation; or had an application for life or health insurance declined, postponed, limited, or issued other than as applied for?	☐	☐

5. Give full details to questions requiring additional explanation.

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on this application are true to the best of my knowledge and belief. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc. Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc. ("MIB"), or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Farm Family Life Insurance Company or its reinsurer(s) any such information. I further authorize United Farm Family Life Insurance Company or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that United Farm Family Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

$_____paid with application.

Dated _____ , this_____ day of_____ , _____
City State Month Year

X _____ **X** _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ❑ is not ❑ intended to replace or change any existing life insurance or annuity coverage.

X _____ **X** _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent E-mail _____

Agent: Phone # _____ Fax#_____ License Identification Number ( ) _____
State

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to
UNITED FARM FAMILY LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192
All premium checks must be made payable to United Farm Family Life Insurance Company.
Do not make check or money order payable to the agent or leave the Payee blank.

FAIR CREDIT REPORTING ACT/MIB, INC. NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Farm Family Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901.

United Farm Family Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.