GREAT WESTERN INSURANCE COMPANY

Great Western Final Expense Insurance

APPLICATION BOOKLET

AGENT INSTRUCTIONS

Please complete the following:

☐ Application for Final Expense Insurance Policy

☐ Bank Draft Information

☐ Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: my.gwic.com/online

Mail
Great Western Insurance Company
P.O. Box 14410
Des Moines, IA 50306-3410

Fax
515-247-2500

If you have any questions, please call 866-252-5594.

43 112 1086 1018 FL

Page intentionally left blank.

GWIC GREAT WESTERN INSURANCE COMPANY

Agent Number: _____

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Application for Individual Life Insurance

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 by a licensed medical doctor as terminally ill, been in hospice, or been committed to or been advised to be committed by a licensed medical doctor to a hospital or nursing home for five or more days? ☐Yes ☐No

2) Is the applicant unable to 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, or any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System or Liver? ☐Yes ☐No
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).

4) Has the applicant been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by HIV infection or other sickness or condition derived from such infection? ☐Yes ☐No

If all 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 is not answered, the policy will be issued with a two-year Graded Death Benefit.

Primary Care Physician	Phone #

D. Policy Information

Face Amount: $	Ultimate Death Benefit: $ *For Level Death Benefit policies, multiply Face Amount by 125%*
Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	Base Premium Amount: $
☐ Dependent Child or Grandchild Rider *$5,000 Face amount and separate application required*	Rider Premium Amount: $ *($1.00 per month)*
	Total Premium Amount: $

Spousal Bonus Rider – Full Name and Date of Birth:
$10,000 Face amount and separate application required

Page intentionally left blank.

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 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 Insured must be alive and in the same health as described above or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the Policy is delivered. Further, 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 might make to the Policy for which I am applying.

Insurable Interest: By signing below, I certify that insurable interest laws are met in the State of Florida.

Authorization: I authorize any healthcare provider, medical facility, pharmacy, 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 re-disclosed 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 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.

Third Party Notice: I understand that I can elect another individual to receive mailed notification of an impending lapse in coverage. If provided, GWIC will send the secondary addressee notice at least 21 days prior to the expiration of the grace period. If I elect to have a secondary lapse notice sent, I will fill out and provide separately to GWIC the contact information for the notice.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

x_____ Signed on:_____ Signed at:_____
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)* State License Identification Number

x_____ _____
Agent's Signature Signed on (mm / dd / yyyy)

Page intentionally left blank.

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Child/Grandchild Protection Plan - Rider Application for Life Insurance

State ☐ *(Print)* Agent Name: _____ Agent Number: ☐ Date: _____

Insured's Information

Full Name			
Social Security #	Sex	Age	Birthdate
Mailing Address			
City	State		
Zip	Phone Number		

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/Grandchildren listed below, who meet the following conditions, will be covered.

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

Children/Grandchildren (add additional pages as necessary)

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

Agreement

Agree 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 accepting the Policy, 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.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed at _____ (Location) on _____ (Date)

Insured **X** _____ (Parent or Guardian, If Juvenile Insured)

Owner **X** _____ (If Other than Proposed Insured)

Agent **X** _____ #_____

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 the Great Western Insurance Company at the address listed above.

Page intentionally left blank.

BANK DRAFT INFORMATION

Complete this section only if you selected the automatic bank withdrawal payment option.

Ongoing Premium

Authorization to Bank or Other Financial Institution

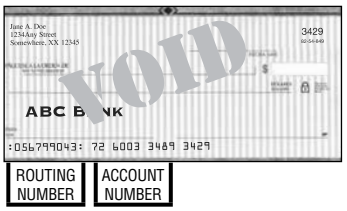
☐ Checking ☐ Savings Requested Withdrawal Date (1st - 28th only) _____

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Great Western Insurance Company (the "Company") for insurance premiums. I authorize the Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

Page intentionally left blank.

GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Life Replacement Advertising

AGENT'S STATEMENT

I,_____ have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X _____
Agent Signature

_____
Agent Number

_____
Date

Complete and Send With Application

Page intentionally left blank.

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Notice Regarding Replacement

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish to receive a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

YES ☐ NO ☐

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

X _____	_____	_____
Applicant's Signature	Applicant's Name (Printed or Typed)	Date
X _____	_____	_____
Agent's Signature	Agent's Name (Printed or Typed)	Date
_____	_____	
Agent's Address (Printed or Typed)	Agent's Company	

Information on policies or contracts which may be replaced:

	Company Name	Policy/Contract No.	Name of Insured
1.			
2.			
3.			
4.			
5.			

Page intentionally left blank.

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

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 receive 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 or 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.

X _____	X _____	_____
Applicant's Signature	Agent's Signature	Date

Page intentionally left blank.

GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Designation of Third Party Notice Contact

Insured's Name: _____ **Owner's Name:** _____

Notice of Your Right to Designate a Third Party Contact

Under law, a policy owner may designate a third party contact to receive notification of a lapse or termination of a policy for nonpayment of a premium. If you want to exercise your option, please complete this form with the name of a third party contact and return it to the address listed above.

Full Name: _____

Relationship to Owner: _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Second Name: ***(Optional)*** _____

Relationship to Owner: _____

Address: _____

_____

Phone Number: _____

Email Address: _____

DATE: _____

SIGNATURE OF APPLICANT: **X** _____

WAIVER OF PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse of this policy for nonpayment of a premium. I elect NOT to designate a person to receive this notice.

DATE: _____

SIGNATURE OF APPLICANT: **X** _____

Page intentionally left blank.

GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Receipt for Initial Premium

Final Expense Receipt

I, the listed agent below, have received an application from _____
(Applicant's Name)

for a Final Expense Whole Life Insurance policy with the following rider:

❒ Dependent Child / Grandchild Rider

Face amount of Life Insurance applied for: $ _____.

Amount of initial premium received by agent: $ _____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If you do not hear from our company within 30 days, please contact us by one of the following methods:

Write to:
Great Western Insurance Company
PO Box 14410 • Des Moines, IA 50306-3410

Call:
Customer Care at 1-800-733-5454

_____ _____
Agent's Signature Date

_____
Agent's Printed Name

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Life Replacement Advertising

AGENT'S STATEMENT

I,_____ have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X _____
Agent Signature

_____
Agent Number

_____
Date

Applicant's Copy

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Notice Regarding Replacement

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish to receive a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

YES ☐ NO ☐

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

X _____	_____	_____
Applicant's Signature	Applicant's Name (Printed or Typed)	Date
X _____	_____	_____
Agent's Signature	Agent's Name (Printed or Typed)	Date
_____	_____	
Agent's Address (Printed or Typed)	Agent's Company	

Information on policies or contracts which may be replaced:

	Company Name	Policy/Contract No.	Name of Insured
1.			
2.			
3.			
4.			
5.			

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

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 receive 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 or 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.

X _____	X _____	_____
Applicant's Signature	Agent's Signature	Date

Page intentionally left blank.