Agent Number:_______________

P.O. Box 14410 Des Moines, IA 50306-3410
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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 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, multiply 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 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)* Agent Number

x____________________________________ ____________________________________
Agent's Signature Signed on (mm / dd / yyyy)