

1. Supplement to Application on :			Check Appropriate Rider	
Proposed Insured:	Application Date:	Policy # (When adding existing rider)	Child Rider # of units <input type="checkbox"/>	Grandchild Rider \$7,500 <input type="checkbox"/>
Address	City	State	Zip Code	

2. Children/Grandchild Proposed for Insurance (Please Print)

Name all natural-born children, stepchildren and legally adopted children or grandchildren for grandchild rider of Primary Proposed Insured who have not attained age 18. Insurance will not be provided on newborn children less than 15 days of age or grandchildren if grandchild riders applied for. (Attach another sheet if necessary):

Full Name of Proposed Insured Child/Grandchild	Age Last Birthday	Sex	Date of Birth	Relationship to Proposed Insured	Height	Weight
A.						
B.						
C.						

3. Health Information

- Has any Proposed Insured Child/Grandchild ever had, been diagnosed or treated for cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs?..... Yes No
- Has any Proposed Insured Child/Grandchild ever had, been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ?..... Yes No
- Has any Proposed Insured Child/Grandchild ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?..... Yes No

Please provide details to any "Yes" answer to Question 1-3 (Attach another sheet if necessary):

Proposed Insured Child/Grandchild	Condition & Treatment	Date	Name & Address of Physician or Hospital

Beneficiary Designation:
Any proceeds payable under this rider will be paid to the Owner, if living. Otherwise, per the beneficiary provision of the rider.

- Does Proposed Insured Child/Grandchild have existing life insurance policies or annuity contracts?.... YES NO
 - Will this insurance replace or change any other insurance policies or annuity contracts? YES NO
- If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: _____

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application
Dated at _____, _____ on this _____ day of _____, _____.
Signature of Grandparent/Parent Guardian _____

Agent Statement:
1. Does the Proposed Insured have any existing life insurance policies or annuity contracts?..... YES NO
2. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms?..... YES NO
Signature of Agent: _____ Agent Number _____