Agent Instruction for Submitting New Application

In addition to the insurance application, the following forms may be required at time of application and should be submitted at the same time as the application:

PPO – Payment Protection Option is an insurance rider on the Grow-Up® policy. There is a separate premium. To qualify, the owner and premium payer must be the same person between 18-50 years of age.

Replacement Form[1] - If Gerber Life policy will replace another policy, complete appropriate state required form. Form must be submitted with application.

NAIC-Replacement Sales/Marketing Materials Form - In compliance with the NAIC Model Replacement Act, if the Gerber Life policy will replace another policy, the Replacement Sales/Marketing form must be completed. Commissions will be withheld until the document is received.

Conditional Receipt- For Check or Money Order ONLY. If check or money order is collected with application, provide Conditional Receipt CRUW to customer and submit copy of receipt with the application and check.*

*In **KS** if a check, money order or authorization of payment is collected with the application, please provide the Temporary Insurance Receipt TIR-2015-KS to customer and submit a copy of the receipt with the application and payment. The receipt must be signed by the agent.

Split Commissions - Split commissions are allowed between 2 agents. Check off Agent Split near the upper right-hand corner of the application. Fill out the Agent Split Request Form located in this kit.

(CA Only) Disclosure to Seniors - If individual is age 65 or older and agent is meeting in their home, provide completed form to individual. A copy should be kept on file (Do Not send to Gerber Life).

(NY Only) Definition of Replacement - Replacements are not allowed in New York, although the Definition of Replacement form must be filled out for all life insurance applications. The document must be signed by the Applicant and the Agent, and a copy left with the Applicant. This document must be returned to the Company with the application. The signed date on the form must be the same signed date as the application.

(NY Only) I Certify Form – In compliance with NY state law, submission of the completed 'I Certify Form' is required to be sent with your application packet verifying your adherence to NY PIF and BG process. Commissions will be withheld until the document is received.

(NY Only) Agent Best Interest Certification – In compliance with NY Regulation 187, it is required that agents act in their customers best interest. This form is a certification that the product selected is in the best interest of the customer. This form must be signed and submitted with all NY applications. Failure to comply will result in the application being closed out.

(NY Only) Producer Checklist – In compliance with NY Regulation 187, agents are required to retain documentation related to recommendations made to a customer regarding life insurance products. This form is for your records only and is not to be submitted with applications.

(NY Only) Life Suitability and Best Interest Questionnaire – In compliance with NY Regulation 187, agents are required to determine the suitability of a product(s), prior to making a recommendation to the customer. This questionnaire is required to establish product suitability in accordance with the NY Regulation 187. One form is required per policy and is owner specific *(you cannot list multiple insureds on one questionnaire.)* This form is required to be completed in full and failure to comply will result in the application being closed out.

• Please follow your Marketing Office procedures for application submission to Gerber Life.

[1] *Replacements are not accepted in following states: CA, DE, FL, ID, IL, KY, MA, NY, PA, PR, TN, WA*

Gerber Life Insurance
445 State Street • Fremont, Michigan 49412
www.gerberlife.com

Agency Application

Agent Name_____ **Agency Name**_____ **Agent #**_____

Agent Phone #_____ **Agent Email** _____ ☐ **Agent Split**

Application for: Individual Whole Life Insurance **GERBER LIFE INSURANCE COMPANY,** White Plains, NY 10605

Amount of Insurance Fill in Amount between $10,000 – $50,000 (in 000's only) $_____

1. Child(ren) *under* **15 years of age to be insured:**

First Name	Last Name	Middle Initial	Sex	Date of Birth Month Day Year

2. YOUR NAME: ☐ Parent ☐ Grandparent ☐ Permanent Legal Guardian (Check one)

First Name_____ **Last Name**_____ **Middle Initial**_____

Address _____ **Apt. #** _____ **City** _____

State_____ **Zip**_____ **Phone ( )** _____

Date of Birth_____ **Sex**_____ **E-mail** _____
(Month Day Year)

3. BENEFICIARY: You will be the beneficiary unless you name someone else below.

Name_____ **Relationship to child(ren)**_____

4. Were any of the children born prematurely or with abnormalities at birth diagnosed by a medical professional? (Skip this question if children are more than 1 year old)..... ☐ **Yes** ☐ **No**

5. Within the past five years have any of the children listed above been treated or diagnosed by a physician for: respiratory disorder, heart disease or disorder, mental disease or disorder, or any other impairments or diseases?..... ☐ **Yes** ☐ **No**

5a. Give full details if you answered "Yes." **Use and sign separate sheet if necessary.**

Name of Child(ren)	Nature of Condition	When condition started	Does your child still have the condition?
			☐ **Yes** ☐ **No**

6. Is there any Life Insurance or Annuity policy in force or applied for on the proposed insured children? If yes, please list below..... ☐ **Yes** ☐ **No**

Child's Name_____ Company_____Amount_____

Will this policy replace a Life Insurance or Annuity policy already in force on the life of the child? ..... ☐ **Yes** ☐ **No**

I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of the Proposed Insured(s)'s personal health information to MIB, Inc. (MIB). In addition, I authorize the MIB to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to the Proposed Insured(s)'s health or other information the Company requires to determine insurability. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine the eligibility of the Proposed Insured(s) for insurance. I agree this Authorization shall be valid for 24 months from the date shown below and that, upon my request, I have the right to receive a copy of this Authorization.

I AGREE THAT: the above answers are true and complete to the best of my knowledge and belief. This application shall be the basis for and a part of the policy. I understand that no insurance shall take effect until this application is approved and the first premium is received by Gerber Life Insurance Company during the lifetime of the insured.

Both the child(ren) and I are citizens or permanent legal residents of the United States.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____
Your Signature Date

X _____
Signature of Parent/Legal Guardian with whom the child(ren) resides (Required, if not the applicant) Date

AGPP-12-MD

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Coverage is dependent on answers to health questions. Issuing your policy and paying your benefits may depend on the answers given in the application.

If the Insured dies by suicide within two years from the Issue Date, the only amount payable will be the premiums paid for the policy, less any debt against the policy.

The following notice applies to applicants in the states of AZ, CA, CT, GA, IL, ME, MA, MN, MT, NJ, NV, NC, OH, OR, and VA: To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

Benefit amounts are subject to Gerber Life insurance limits.

Policy Form ICC12-GPP

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the 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. Gerber Life Insurance Company, or its reinsurers, may also release information from its file to other 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.

MIB-14

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

Primary Agent Name: _____ **Agent #:** _____

Agency Name: _____ **Applicant's Name:** _____

SECONDARY AGENT - AGENT SPLIT REQUEST

Please review the following outline of requirements:

- ✓ This form must be sent in at time of application in order for a split commission to be applied.
- ✓ Split Commissions are allowed between two agents only.
- ✓ The name, agent ID, and split percentage for the secondary agent must be included in the request.
  - – If the percentage of the split is missing, it will default to 50% for each agent for the life of the policy.

Please provide secondary agent information for split commissions:

First Name: _____

Last Name: _____

Gerber Life Agent ID: _____
(If agent ID is not known, write in 9999-9999)

Percent of Split: _____ **%**

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445 State Street • Fremont, Michigan 49412
www.gerberlife.com

Payment Protection Option Rider

Agent Name_____ **Agent #**_____

Gerber Life Insurance Company
445 State Street, Fremont, MI 49412

Application for Payment Protection Option

1. Your Name: _____

2. Your Date of Birth: ____ ____ ____

3. Are you the person paying for the child's Grow-Up® Plan?. . . . . ☐ Yes ☐ No

4. Children insured by a Grow-Up® Policy:

_____

_____

_____

5. Are you currently unable to work or perform your normal activities, or have you applied for disability benefits within the last 5 years or have you been diagnosed by a medical professional with a terminal illness (death within 12 months)?. . . . . ☐ Yes ☐ No

I AGREE THAT: The above answers are true and complete to the best of my knowledge and belief. This application shall be the basis for and part of the option/rider. I understand that no insurance shall take effect until this application is approved and the first premium is received by Gerber Life Insurance Company during the lifetime of the owner.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Both the child(ren) and I are citizens or permanent legal residents of the United States.

_____ _____

6. Your Signature **Date**

ICC13-APPO

- **For Owners 18-50 years of age**
- **Owner and payer must be the same**

IMPORTANT NOTICE

GERBER LIFE INSURANCE COMPANY
1311 Mamaroneck Avenue
White Plains, NY 10605
800-253-3074

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document shall be signed by the applicant and the insurance producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing life insurance policy or annuity contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ____ YES ____ NO

2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? _____ YES _____ NO

If you answered "yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary, or available disclosure document must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer in the sales presentation. Be sure you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because:

I certify that the responses herein are, to the best of my knowledge, accurate.

Applicant's Printed Name

Applicant's Signature _____ Date

Insurance Producer's Printed Name

Insurance Producer's Signature _____ Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare life insurance policies or annuity contracts. You should discuss the following with your insurance producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You are older -- are premiums higher for the proposed new life insurance policy?

How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

LIFE INSURANCE POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old life insurance policy may have been paid, and you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new life insurance policy?

Does the new life insurance policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new life insurance policy.

Claims on most new policies for up to the first 2 years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing life insurance policy be affected?

Will a loan be deducted from death benefits?

What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?

What are the interest rate guarantees for the new annuity contract?

Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old life insurance policy under the Internal Revenue Code?

Will the existing insurer be willing to modify the old life insurance policy?

How does the quality and financial stability of the new company compare with your existing company?

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

REPLACEMENT

SALES/MARKETING FORMS

APPLICANT NAME: _____

APPLICATION STATE: _____

AGENT NAME: _____

AGENT#: _____ **AGENCY:** _____ **DATE:** _____

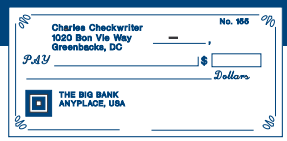
In compliance with NAIC Model Replacement Act, listed below are the Marketing/Sales forms used in the sale of this application:

Please use full Gerber Life Form# shown at the bottom of the Marketing/Sales material

Form # _____
Form # _____
Form # _____
Form # _____
None _____

Gerber Life will not charge your account any money until 3 days after your application is approved.

How to pay your premiums automatically through your CHECKING ACCOUNT:



1. Complete and sign the Authorization Form below.
2. Please provide the required financial information. Contact your financial institution for the correct account and routing numbers.
3. Your first premium will be withdrawn 3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
4. Premiums will continue to be automatically withdrawn each month unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on this Form.

How to pay your premiums automatically through MASTERCARD or VISA:

1. Complete and sign the Credit Card Authorization Form below.
2. Your first premium will be charged 3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
3. Premiums will continue to be charged monthly to the credit card you select, unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on the Form.

Questions? Call our toll-free number: **1-800-428-4947** Monday-Friday, 8:30am to 6pm (EST)

Use this Authorization Form for payment by automatic withdrawal from CHECKING ACCOUNT

☐ **Yes,** I hereby authorize the bank or financial institution named below to pay my insurance premiums as indicated below, by automatic withdrawal from my checking account. **I understand that my 1st premium will not be withdrawn until 3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____

Insured's name: _____ **Date of Birth:** _____

Name of Financial Institution _____

Type of Account: ☐ **Checking** ☐ **Savings** **Bank Transit #** _____ **Account #** _____

X _____ **Date** _____
(Accountholder's Signature)

Preferred Payment Date _____ **If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age.**

Please automatically withdraw my premiums every (check ☑ one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

Use this Credit Card Authorization Form for payment by MASTERCARD or VISA

☐ **Yes,** please charge my premiums to my credit card account. **I understand that my 1st premium will not be withdrawn until 3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Please check ☑ one: ☐ **Mastercard – Must contain 16 numbers** ☐ **VISA – Must contain 13 or 16 numbers**

Card Number: _____ **Exp. Date** _____

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____

Insured's Name: _____ **Date of Birth:** _____

X _____ **Date** _____
(Cardholder's Signature)

Preferred Payment Date _____ **If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age.**

Please charge my premiums every (check ☑ one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

GERBER LIFE INSURANCE COMPANY • Home Office: 1311 Mamaroneck Avenue, Suite 350, White Plains, NY 10605

CONDITIONAL RECEIPT FOR UNDERWRITTEN POLICIES

THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. PAYMENT IN CASH IS NOT ACCEPTABLE.

All checks and money orders must be made payable to: GERBER LIFE INSURANCE COMPANY.

Any insurance under this Conditional Receipt will be effective from the date of the completed application, or the date of the last medical examination required by the Company's established rules, whichever is later, provided that all of the following conditions have been fulfilled:

1. The first premium is paid by the date of the completed application by check or money order that is honored and collectable; and

2. On the date of the completed application or the date of the last medical examination, if required, whichever is later, the proposed insured is insurable and acceptable for the insurance, exactly as applied for, as determined by Gerber Life Insurance Company, under its underwriting rules and practices for the plan and amount of insurance applied for and at the Company's standard premium rate.

The amount of any insurance effective under this Conditional Receipt is limited to the lesser of the amount applied for in the application or $25,000.

Any insurance under this Conditional Receipt ends at the earlier of 1) sixty (60) days from the date of the completed application, 2) the date the policy is approved, which is the Policy Date, or 3) the date the proposed insured is determined to be uninsurable.

If the conditions under this Conditional Receipt are not satisfied, no insurance of any kind will be in effect and the payment will be returned to the applicant.

THIS CONDITIONAL RECEIPT DOES NOT PROVIDE ANY TEMPORARY OR INTERIM INSURANCE COVERAGE.

Received from _____ the sum of $_____ paid by check or money order at the time of signing the insurance application.

The proposed insured is: _____

Date _____ Signature _____ Agent#_____
Month /Date/ Year Licensed Agent

Date _____ Signature _____
Month /Date/ Year Proposed Insured

CRUW-2011-MD

Agent Instructions:

PLEASE NOTE THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT AND A COPY MUST BE SENT TO GERBER LIFE INSURANCE WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. THIS MUST BE DONE AT THE TIME OF APPLICATION. ADDITIONALLY, THE CONDITIONAL RECEIPT, APPLICATION AND THE CHECK MUST ALL HAVE THE SAME DATE.

Name of Proposed Insured:_____ **Application number:**_____

GERBER LIFE INSURANCE COMPANY

Authorization to Obtain, Use, and Disclose Personal Information (Insurance Eligibility)

PURPOSES

This authorization applies to any Personal Information (defined below) that may be obtained, used, or disclosed about the Proposed Insured by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

PERSONAL INFORMATION

I understand and agree that the types of "Personal Information" that may be obtained, used, or disclosed about the Proposed Insured on the basis of this authorization may include, to the extent permitted by law:

(i) any and all health records about the Proposed Insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,

(ii) non-health information about the Proposed Insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

AUTHORIZATION FOR OTHERS TO DISCLOSE TO US

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the Medical Information Bureau (MIB); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of Personal Information about the Proposed Insured does not apply to this authorization.**

AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

FAILURE TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

DURATION AND REVOCATION

Unless revoked earlier, this authorization will remain in effect for 24 months* from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company
ATTN: Underwriting Department
445 State Street
Fremont, MI 49412

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

COPIES OF THIS FORM

I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured. I also understand that I am entitled to obtain a copy of this authorization form.

_____ _____

Date Signature of Proposed Insured or Authorized Representative

_____

Relationship to Proposed Insured

*For residents in the state of Minnesota, unless revoked earlier, this authorization will remain in effect for 12 months from the date signed.