

Proposed Insured: _____ <small>(First) (Middle) (Last)</small>			Telephone interview done (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address: (No. & Street) _____			_____ <input type="checkbox"/> am <input type="checkbox"/> pm	
City: _____ State: _____ Zip Code: _____			Phone _____ Best time to call _____	
			E-mail Address _____ @ _____	

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Mo. Day Yr / /	Age _____	State of Birth _____	SS# _____	Height: _____ ft _____ in	Occupation: _____
				DL# _____	Weight: _____ lbs	Annual Salary: \$ _____

Owner: Name _____	SS# _____	Address: _____
Payor: Name _____	SS# _____	Address: _____

<b>Primary Insured:</b> Primary Beneficiary _____	Relationship _____
Contingent Beneficiary _____	Relationship _____

<b>Plan:</b> _____ <input type="checkbox"/> Return of Premium (not available on 10 year term plan)	<b>Face Amount</b>
During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

<b>Riders:</b> <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> CIA _____ Units	<b>Policy Date Request:</b> / /
<input type="checkbox"/> Disability Income \$ _____ <input type="checkbox"/> Critical Illness _____ % <input type="checkbox"/> Other _____	<b>Mail Policy:</b> <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Owner

<b>Mode:</b> <input type="checkbox"/> Bank Draft <input type="checkbox"/> Draft 1st Prem on Req. Date <input type="checkbox"/> Payroll Deduction	<b>CWA:</b> <input type="checkbox"/> E-Check Immediate 1st Prem
<input type="checkbox"/> Qtrly <input type="checkbox"/> Other _____ Modal Prem \$ _____	<input type="checkbox"/> Collected \$ _____

Do you have any existing life or disability insurance or annuity contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	Company _____
Will you replace an existing life or disability insurance policy or an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy # _____ Amount of Coverage \$ _____

Other Proposed Insureds: Name	Rider	Amt.	Sex	Birthdate	St. of Birth	Height	Weight	Relationship

**SECTION A: Answer Questions 1, 2 and 3 for all Proposed Insureds.**

1. Has any Proposed Insured been diagnosed or treated for, taken medication for or currently under treatment for (*circle condition that applies*):
  - a. high blood pressure, heart attack, angina, arrhythmia, aneurysm, stroke, TIA, heart or circulatory disease or disorder? ..... Yes  No
  - b. diabetes, pancreas disorder, hepatitis, Crohn's Disease, ulcerative colitis, liver or digestive disease or disorder? ..... Yes  No
  - c. cancer in any form, lung disease or disorder, seizures, mental or nervous disorder, bi-polar disorder, paralysis, blindness? ..... Yes  No
  - d. any disease or disorder of the kidneys, urinary bladder, prostate, reproductive organs, or sexually transmitted disease? ..... Yes  No
  - e. connective tissue disease, systemic lupus (SLE), anemia, arthritis, or any disorder of the back, joints, muscles? ..... Yes  No
  - f. any other disease or disorder, injury, surgery **within the past 24 months**? ..... Yes  No
2. **Within the past 2 years** has any proposed insured participated in parachuting, hang gliding, rock or mountain climbing, rodeo events, sky diving, scuba diving, organized racing of any kind, any professional sport, or aviation? ..... Yes  No
3. Has any Proposed Insured:
  - a. been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? Yes  No
  - b. **within the past 5 years**, been convicted of any misdemeanor or felony charge, had their driver's license suspended or revoked, or convicted of driving under the influence of alcohol or drugs, or driver's license currently suspended or revoked? ... Yes  No
  - c. **within the past 5 years**, used illegal drugs, abused alcohol or drugs, or had or been recommended by a medical professional or licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drug use? ... Yes  No
  - d. **within the past 6 months**, been on probation, parole, or been prohibited from actively working full time (30 hours or more per week) at their regular occupation due to any illness, injury, or health related problem, or are you **currently** disabled? ..... Yes  No
  - e. **within the past 12 months**, consulted a physician, had surgery, been hospitalized, or had diagnostic tests such as EKG, Xray, MRI, CAT scan? ..... Yes  No
  - f. **within the past 12 months**, had diagnostic testing, surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received? ..... Yes  No

**SECTION B: If applying for Critical Illness Rider answer Question 4. (Provide: name, relationship, age at onset, medical condition.)**

4. Has primary insured had a natural parent, brother or sister, suffer from diabetes, kidney disease, require a major organ transplant or been diagnosed with heart disease, cerebrovascular disease, or internal cancer prior to age 60? ..... Yes  No

**SECTION C: Give details to all "Yes" answers in Sections A and B and list current medications (use COMMENTS section on back for additional space).**

Illness, Injury, Disease, or Symptoms	Dates	Treatment	Name and Address of Physician and/or Hospital
	/ /		
	/ /		
	/ /		

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AGREEMENT**—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits and (4) The insurance applied for herein shall not be in effect unless the full premium is paid. Such premium shall be paid in cash or by completion of the appropriate allotment authorization. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

**AUTHORIZATION**—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

**CERTIFICATION**—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

*I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB Pre-Notice. I acknowledge receiving the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.*

Signed at \_\_\_\_\_ Date of Application \_\_\_\_\_  
CITY STATE MONTH DAY YEAR  
\_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

**AGENT'S REPORT**

*I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.*

Does the proposed insured have any existing life or disability insurance or annuity contract? .....  Yes  No  
Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity? .....  Yes  No

Agent \_\_\_\_\_ No: \_\_\_\_\_ % Agent \_\_\_\_\_ No: \_\_\_\_\_ %  
SIGNATURE SIGNATURE

**PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN**

Insured \_\_\_\_\_ Account Holder \_\_\_\_\_  
Financial Institution (name/address) \_\_\_\_\_  
Transit / ABA Number \_\_\_\_\_ Account Number \_\_\_\_\_  Checking  Savings Requested Draft Day (1st-28th) \_\_\_\_\_

**ATTACH VOIDED CHECK OR DEPOSIT SLIP**

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Occidental Life Insurance Company of North Carolina, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records) \_\_\_\_\_ DATE \_\_\_\_\_

**NOTICE**

**Printed in compliance with Public Law 91-508**

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. Occidental Life Insurance Company of North Carolina, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-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 in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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.

Occidental Life Insurance Company of North Carolina, 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](http://www.mib.com).