APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Agent Number: _____

Great Western Insurance Company
Mail policies to: P.O. Box 9160 Ogden, Utah 84409-9160 • Phone: 866-252-5594
Email: fepolicies@gwic.com • Fax: 801-689-1929

A. Proposed Insured *(Full legal name)*

First Name	Middle Initial	Last Name		
Street Address	City		ST	Zip
Phone #	Date of Birth (mm/dd/yyyy)		Social Security #	
Sex: ❑Male ❑Female	E-mail Address			

B. Owner *(Complete only if other than the proposed Insured)*

First Name	Middle Initial	Last Name		
Street Address	City		ST	Zip
Phone #	Date of Birth (mm/dd/yyyy)		Social Security #	
Sex: ❑ Male ❑ Female	E-mail Address		Relationship to Insured	

C. Health Questions

1) In the last two years, has the applicant been a patient in hospice, a hospital, or 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), any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System or Liver? Maintenance medications are not considered treatment if the prescription has remained the same (or generic equivalent) at the same or decreased dosage for the past two years. ❑ YES ❑ NO

If all health questions are answered "NO," the proposed Insured is eligible for a Level Death Benefit. If any of the health questions are answered "YES," or are not answered, the Policy will be issued with a Graded Death Benefit.

Primary Care Physician (*Required for Level Death Benefit)*	Phone #

D. Policy Information

Face Amount: $	Ultimate Death Benefit: $ *For Level Death Benefit policies, multiply Face Amount by 120%*
Payment Mode: ❑ Monthly ❑ Quarterly ❑ Semi-annually ❑ Annually	Base Premium Amount: $
❑ Dependent Child/Grandchild Rider *(complete separate application)* *Minimum $5,000 Face Amount on base Policy required*	Rider Premium Amount: $
	Total Premium Amount: $

Spousal Bonus Rider – Full Name and Date of Birth:
Minimum $10,000 Face Amount on each Policy required

Proposed Insured Last Name: _____

E. Beneficiary Information *(Use additional form for more beneficiaries)*

Primary *(Full legal name)*		Relationship	
Street Address	City	ST	Zip
Contingent *(Full legal name)*		Relationship	
Street Address	City	ST	Zip

F. Agreement

By signing below, I agree to the following: (1) To the best of my knowledge and belief, statements in this Application are complete and true. (2) The Policy issued by Great Western Insurance Company (GWIC) is based on, and only on, the statements and answers in this Application. (3) I will notify GWIC of any changes in the statements or answer given in this Application between the time of the application and delivery of the Policy. (4) GWIC will have no liability until a Policy is issued on this Application and delivered to and accepted by the Owner. (5) The full modal premium must be paid and the policy delivered while the Insured is alive. 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 may make to the Policy for which I am applying.

Insurable Interest: By signing below, the Owner certifies that he/she has insurable interest in the life of the Insured as defined by the law in the state in which the Policy is issued.

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 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 offense and subject to penalties under state law.

G. 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 now or recently 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 the Proposed Insured)* *(mm/dd/yyyy)* (City, State)

H. 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 now or recently in force? ❑ YES ❑ NO

_____ _____
Agent Full Name *(Please print)* Agent Number

X _____ _____
Agent Signature Signed on: *(mm/dd/yyyy)*