Agent Number: _____

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

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

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 diagnosed as terminally ill, been in hospice, or been confined to or been advised to be confined to 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), 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," 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, multiple 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: $ *($1.00 per month)*
	Total Premium Amount: $

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

Proposed Insured's Last Name: _____

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 of North Dakota.

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 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 fine and confinement in prison.

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 on: _____
Proposed Insured's Signature (mm / dd / yyyy) (City, State)

x _____ Signed on: _____ Signed on: _____
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)

Premium Authorization Withdrawal Form

(Complete one form per Applicant)

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

Proposed Insured *(Full legal name)*

First Name	Middle Initial	Last Name

Payor Information

☐ Insured ☐ Owner ☐ Other Relationship: _____

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

Bank Account Information

Financial Institution (Bank Name):

☐ Checking ☐ Savings *Contact your bank to verify EFT is allowed*

Routing Number (lower left corner of check) | | | | | | | | | |

Bank Account Number (lower middle of check) | | | | | | | | | | | | | |

Credit Card Information

Credit Card | | | | | | | | | | | | | | | | |

Exp. Date | | | | | M M Y Y

CVV | | | |

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

I hereby authorize Great Western Insurance Company (the Company) to initiate debit entries. If necessary, the Company may credit entries on the above named financial institution and account. This authorization is to remain in full force and effect until the Company receives written notice of its termination. The notice must be in such time and in such manner as to allow the Company and Depository reasonable time to act (minimum of three weeks). If I select a specific date for the first payment, I authorize the Company to withdraw on or after the specified date as indicated below.

First payment to be ☐ drafted immediately
☐ drafted on specific date: _____
☐ paid by check

Subsequent payments to be drafted ☐Mo ☐Qtr ☐Semi ☐Ann on ☐ a specific day _____ (1–28)
☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Amount of Premium: $

Accountholder / Cardholder's Name *(Please Print)* _____

Accountholder / Cardholder's Signature _____ Date _____

Great Western Insurance Company

P.O. Box 3428 • Ogden, UT 84409-1428 • (866) 689-1401 • Fax (801) 689-1391

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer and a copy left with the applicant.

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

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 policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or 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 policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing 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 policy or contract? ____ YES ____ NO

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

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or 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 policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

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

_____
Applicant's Signature, Printed Name and Date

_____
Producer's Signature, Printed Name and Date

BE SURE TO READ
THESE IMPORTANT POINTS TO CONSIDER

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 policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or 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 policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

Policy Values:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisitions costs for the old policy may have been paid; 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 policy?
- Does the new policy provide more insurance coverage?

Insurability:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

If You Are Keeping The Old Policy As Well As The New Policy:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

If You Are Surrendering An Annuity Or Interest Sensitive Life Product:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

Other Issues To Consider For All Transactions:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

INFORMATION ON THE ACCELERATED DEATH BENEFIT RIDER

INCLUSION OF RIDER

If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER

Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the Insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION

Qualifying Medical Condition means either: 1) Terminal Illness - You are terminally ill. You are expected to die within 12 months or 2) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS

The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the Insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT

The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE

This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs such as Medicaid. Prior to electing to buy the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS

This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care, nursing home, or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION

When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

CHILD/GRANDCHILD PROTECTION PLAN

Rider Application for Life Insurance

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

State _____ Print Agent Name _____ Agent Number _____

Insured's Information

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

Child/Grandchild Protection Rider Information

Existing Policy #	Rider Premium $1.00 per month

Does the applicant have any existing policy or annuity? ❑ YES ❑ NO
Will the proposed insurance replace any existing policy or annuity? ❑ YES ❑ NO
If "Yes," please complete a replacement form.

Conditions of Child/Grandchild Protection Plan

I apply for the Child/Grandchild Protection Plan and understand that only the Covered Child/Grandchildren listed below, who meet the following conditions, will be covered.

- The Covered Child/Grandchild has never been married and is living with a parent, grandparent, or guardian at the time of death.
- The Covered Child/Grandchild is at least one year of age and has not attained the age of 18 years.
- The Covered Child/Grandchild died while the Insured on the base Policy was alive.
- The coverage under the base Policy to which this Policy is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth

Agreement

Agreement: By signing below, I agree that: (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child/grandchildren must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By accepting the Policy, I approve any change(s), correction(s), or additions(s) that Great Western made when issuing it. If my approval requires written consent, a form will be included.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X _____ Signed on: _____ Signed at: _____
Insured's Signature (mm/dd/yyyy) (City, State)
(Parent or Guardian, if Juvenile Insured)

X _____ X _____ State License #: _____
Owner's Signature Agent Signature
(If other than the Proposed Insured)
Replacement of insurance is involved. ❑ YES ❑ NO

To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.