

<b>A. All Applications</b>		<b>Proposed Insured</b> (print full name):		Place of Birth (country):	
Home Street Address:			City:	State:	Zip:
Social Security No.:	Birth date (mm/dd/year)	Gender:	Height:	Weight:	
Occupation:			Annual Income: \$		
Phone: Home: _____ Work: _____		Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (if, no submit copy of valid permanent resident card)			
Have you smoked cigarettes in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No    24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Premium with Application \$ _____ <input type="checkbox"/> Ann <input type="checkbox"/> SA <input type="checkbox"/> Qtr <input type="checkbox"/> Monthly Direct Bill (PT2/PT3) <input type="checkbox"/> EFT (complete EFT form)			
Primary Beneficiary/Relationship:			Contingent Beneficiary/Relationship:		

**Will there be an owner/payor on the policy other than the proposed insured? If so, complete owner/payor information**

<b>B. Owner</b> Name of Policy Owner: _____ Billing Address: _____ _____	Social Security No. of Owner: _____ Special Requests/Endorsements: _____
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**Which product do you want?**

<b>C. Life Insurance</b> Amount \$ _____ Plan _____ Item No. _____ Do you want to be considered for Premier Rates? ___ Decreasing Term Period _____ <b>Additional Benefits</b> ___ Disability Waiver of Premium ___ Accidental Death Benefit.....\$ _____ amount ___ Guaranteed Purchase Option \$ _____ per option ___ Guaranteed Renewability Benefit ___ Other _____	<b>D. Disability Income Insurance</b> ___ Individual Disability Benefit - Item 235    Waiting Period _____ Days ___ Mortgage Payment Disability Benefit - Item 212 - 60 Day WP (If selected, complete Section C) Benefit Amount \$ _____ Benefit Period Yrs _____ Occupational Class _____ Annual Income \$ _____ Annual Net Income, if self-employed \$ _____ Other Income \$ _____ Explain _____ ___ Item 237 - Accidental Death and Dismemberment \$ _____ ___ Item 236 - First Day Disability Income While Hospital Confined
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**E. LIFE AND DISABILITY**

Please answer the following questions in every case and provide details in #5

**DO NOT COLLECT MONEY AND ISSUE BINDING RECEIPT WHEN ANSWERS TO QUESTIONS ARE 'YES' OR 'BLANK'**

- Do you have or during the past 10 years have you been diagnosed or treated by any physician or other practitioner for:
  - Heart disease or disorder, angina, stroke or cancer? Yes \_\_\_ No \_\_\_
  - Acquired Immune Deficiency Syndrome? Yes \_\_\_ No \_\_\_
- Are you currently unemployed, retired, laid off or collecting disability? Yes \_\_\_ No \_\_\_
- During the past 5 years have you been absent from work due to accident or sickness for more than 10 days at a time? Yes \_\_\_ No \_\_\_
- During the past 90 days have you been admitted to or been advised to be admitted to a hospital or medical facility by any physician or other practitioner? Yes \_\_\_ No \_\_\_
- Please provide details to all questions answered 'yes'

**For the Agent: Does the policy applied for replace or change any other insurance presently in force covering proposed insured?**

Yes  No

Did you see proposed insured? Yes  No

**Prior Carrier Name:**

**Prior Carrier Policy Number:**

Proposed Insured (print full name) \_\_\_\_\_

**IT IS UNDERSTOOD AND AGREED:** (1) That all answers to the questions on page 1 of **this application** are complete and true to the best of my knowledge and/or belief. (2) That all answers to such questions, together with this agreement, shall form the basis and become a part of any policy issued. (3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the date of the application subject to terms and limitations of the Binding Receipt; otherwise, benefits shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability as stated in the application, of the person to be insured. (4) That acceptance of any policy issued on this application will constitute a ratification of any correction in or addition to this application made by the Company and noted in the space for Home Office endorsement, provided, however, no change shall be made as to amount, classification, plan of insurance, or benefits, unless agreed to in writing. (5) Only the President or Secretary of the Company can make, modify, alter or discharge contracts or waive any of the Company's rights or requirements.

**THE AGENT AND I CERTIFY** that I have read, or the agent has read to me, the completed application. I realize that any false statement or misrepresentation in my application may result in the loss of coverage under the policy (subject to the incontestability provision, time limit on certain defenses, and legal proceedings). I also acknowledge receipt of NOTICE OF INFORMATION PRACTICES.

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to criminal and civil penalties.**

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I **authorize** any health plan, physician care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the Medical Information Bureau, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Auto-Owners Life Insurance Company or its reinsurer(s) my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Auto-Owners Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) Obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Auto-Owners Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I acknowledge having received a copy and that I have read it, and its terms, conditions and limitations, to which I agree have been explained to me. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Auto-Owners Life Insurance Company, I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Auto-Owners Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I **AUTHORIZE** any licensed physician, medical practitioner, hospital, clinic or other medical or medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person having any records or knowledge of me or my health, to give to Auto-Owners Life Insurance Company or its reinsurer(s) any such information. I understand this authorization is valid for 26 months from the date it is signed. A copy of it is also valid. I Acknowledge having received a copy and that I have read it, and that its terms, conditions and limitations, to which I agree have been explained to me. I understand that I have the right to revoke this at any time.

**For the Agent: Does the policy applied for replace or change any other insurance presently in force covering proposed insured?**

Yes  No  If yes, provide name and policy number of carrier \_\_\_\_\_

Signed in the State of \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Signature of Proposed Insured)

\_\_\_\_\_  
(Agent's Signature)

\_\_\_\_\_  
(Agency & Producer code)

\_\_\_\_\_  
(Signature of Owner/Applicant-If Other Than Proposed Insured)

\_\_\_\_\_  
(Agent's Name - Please Print)

Must be submitted with application to Auto-Owners Life Insurance Company

**BINDING RECEIPT FOR LIFE AND/OR DISABILITY INCOME INSURANCE**

NOTICE: No Binding Receipt shall be issued and no insurance will take effect if questions E 1, 2, 3 or 4 are left blank or are answered "yes" with respect to anyone applying for coverage or when life insurance benefits applied for on any person on this and all other pending applications with Auto-Owners Life Insurance Company exceeds \$1 million.

Auto-Owners Life Insurance Company has received \$ \_\_\_\_\_ with the application for life insurance on \_\_\_\_\_ and/or \$ \_\_\_\_\_ for Disability Income insurance on \_\_\_\_\_

In consideration of the application and premium payment, death and/or disability benefits applied for shall take effect on the date of the application, subject to the following terms and limitations:

- 1. No person under the age of 15 days is included under this Binding Receipt for life insurance. No person under the age of 18 years or over the age of 60 years is included under this Binding Receipt for disability insurance.
- 2. There are no life and/or disability benefits under the Binding Receipt if:
  - a. during the past 10 years, anyone applying for insurance has been diagnosed or treated by any physician or other practitioner for or had any knowledge of:
    - heart disorder or disease, angina, stroke, or cancer; or
    - Acquired Immune Deficiency Syndrome, (AIDS); or
  - b. during the past 90 days was admitted to, or was advised to be admitted to, a hospital or medical facility by any physician or practitioner; or
  - c. the application contains any material misstatements or material misrepresentations; or
  - d. death is by suicide.
- 3. There are no disability benefits under this Binding Receipt, if during the past 5 years anyone applying for this coverage has been absent from work due to accident or sickness for more than 10 days at a time, or is currently unemployed or laid-off.
- 4. Until the application is approved as applied for or insurance under this Binding Receipt ends:
  - a. The total life insurance death benefit for anyone included under this Binding Receipt will not exceed the lesser of all death benefit amounts applied for or \$250,000.

b. The total monthly disability benefit for anyone included under this Binding Receipt will not exceed the lesser of all disability benefits applied for or \$1,000 per month. Disability benefits are payable for a period of total disability that begins due to an accident that occurs or sickness that first manifests itself after the date of the application and will continue during total disability for 120 days.

- 5. Insurance under this Binding Receipt ends when any one of the following happens:
  - a. a policy is offered to the policyowner that is different than applied for. Death and/or disability benefits offered shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability, as stated in the application, of the person(s) to be insured; or
  - b. the tenth day after the date Auto-Owners Life Insurance Company mails notice of termination of the Binding Receipt to the applicant at the address given in the application; or
  - c. the applicant is personally given notice of termination of the Binding Receipt by an authorized representative of Auto-Owners Life Insurance Company; or
  - d. 120 days have passed since the date of this Binding Receipt.
- 6. If the application is approved as applied for, death and/or disability benefits provided under this Binding Receipt shall be replaced by death and/or disability benefits applied for to take effect on the date of the application.
- 7. This Binding Receipt and the application are the entire agreement between Auto-Owners Life Insurance Company and the applicant.
- 8. The premium submitted with the application will be refunded if the policyowner does not accept the policy, if Auto-Owners Life Insurance Company declines to issue a policy or when the 120 day period has passed. Any premium payment due and unpaid will be deducted from any death and/or disability benefits payable under this Binding Receipt.

\_\_\_\_\_  
Date

Auto-Owners Life Insurance Company  
Lansing, Michigan 48909

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Agent's Signature

**Alabama requires that all premium checks must be payable to the insurance company -- do not make check payable to the agent or leave the payee blank**

**TO BE DETACHED AND RETAINED BY PROPOSED INSURED  
NOTICE OF INSURANCE INFORMATION PRACTICES**

This Life and Disability insurance form gives personal data about the persons to be covered. Sometimes, we may need to seek more personal data from other sources. If we ask for an investigative consumer report, you have the right to ask for an interview with the reporting agency. All such personal data is treated as confidential. In some cases, however, that data may be disclosed to others without an authorization. You have a right of access to this personal data. You may also correct any errors in the data we might collect. You can learn more about these rights and our practices upon request.

**MEDICAL INFORMATION BUREAU, INC. (MIB)**

Data about your insurability will be treated as confidential. Auto-Owners Life Insurance Company or its insurers may, however, make a brief report on it to the MIB. MIB is a not-for-profit group of life insurance companies. It runs a data bank for its members. If you apply to a member company for Life or Disability insurance, the MIB may be asked to supply that company with any data in its files. This may be done also when you make a claim for benefits to a member company.

You have the right to ask the MIB to disclose any data it may have in a file on you. You also have the right to correct any errors in such a file. This is set out in the Federal Fair Credit Reporting Act. You can write to the MIB at P.O. Box 105, Essex Station, Boston, MA 02112. Their phone number is (866) 692-6901.

Some people may try to conceal information relevant to their insurability. This causes unfair expense for everyone else. The MIB is there to protect members and policyholders from this. Data from the MIB may alert the company to check further. The MIB does not show what action is taken on an application.

Auto-Owners Life Insurance Company or its reinsurers may also make a disclosure to other Life companies you apply to for Life or Disability insurance. The same thing may be done when you make a claim for benefits.

**CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS**

You need to know that when you apply for insurance with us, we may ask for a report from a consumer reporting agency. The report could include interviews with you, your neighbors, friends, etc. What we learn is used to determine insurability. It may cover data as to character, reputation, personal characteristics, and mode of living. Data gathered for such a report may be kept by the agency preparing it and disclosed to others.

If you write to us, we will tell you if such a report was made. We will also tell you the nature and scope of the report. This will be done in a reasonable time once we receive your letter. We will also tell you who made the report. You can then contact them for a copy of the report.

**MEDICAL RECORD INFORMATION**

We underwrite each application to help keep the price reasonable. This also helps each person to pay a fair share of the cost in line with the risk each represents. To do this we ask about your physical or mental illness, medical history or treatment. Your application gives some of these answers. We may ask your doctor, hospital, etc., for more details. We may ask you to take an examination. You have the right to amend or correct any personal information we collect. Write us if you want us to do this: Auto-Owners Life Insurance Company, Life Underwriting, Box 30660, Lansing, MI 48909.

**AUTHORIZATION AND ACKNOWLEDGEMENT**

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life or Disability insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration, the Medical Information Bureau, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about me or my child may also release it.

I UNDERSTAND that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

**INSURANCE FRAUD**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**AUTO-OWNERS LIFE INSURANCE COMPANY P.O. BOX 30660 LANSING, MICHIGAN 48909**

An experienced professional from LabOne will be contacting you shortly. This representative will be asking you detailed personal medical and non-medical questions. Depending on your medical history, the average interview will take approximately 15 minutes. You should have the following available for your interview.

- Driver's License Number
- Name(s) and dosage(s) of all the medications you are using
- Name(s) and contact information of your primary physician. Also information on specialists you have seen in the past 10 years.