

Delayed Effective Date Requested:				APPLICATION FOR SIMPLIFIED TERM LIFE INSURANCE POLICY					
1. Your Name (Print)				Sex	Date of Birth		Age	Place of Birth	Social Security No.
First	Middle	Last	(Former)	<input type="checkbox"/> M <input type="checkbox"/> F	Mo.	Day	Year		- -
Street Address			City	County	State	Zip	(Within City Limits) <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Telephone () -
2. Occupation		3. Plan (circle) 5 yr 10 yr 15 yr 20 yr		4. Face Amount \$	5. Premium Amt \$			<input type="checkbox"/> A <input type="checkbox"/> S/A <input type="checkbox"/> Q <input type="checkbox"/> EFT <input type="checkbox"/> Single	Business Telephone () -
6. Primary Beneficiary		Relationship	Social Security No.	Contingent Beneficiary		Relationship	Social Security No.		
			- -				- -		
7. Will the proposed insured replace any existing life insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give name of company, address and Policy No.									
8. Policy Owner		Name						Social Security No.	
		Address						Relationship	

Section I. PRIMARY CARE PHYSICIAN INFORMATION:

1. List the name, city, phone number and specialty for your current primary care physician. If you have more than one doctor, list each doctor. List the date last seen for each doctor:
 - a. _____

Physician's Name	City	Area Code	Phone Number	Specialty	Date Last Seen
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 - b. _____

Physician's Name	City	Area Code	Phone Number	Specialty	Date Last Seen
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Section II. IF ANY OF THESE QUESTIONS ARE ANSWERED "YES," NO COVERAGE CAN BE OFFERED (OTHER PLANS MAY BE AVAILABLE SUBJECT TO FULL UNDERWRITING)

Have you so far as you know and believe:

1. Within the past 5 years been diagnosed, treated for, tested positive for or been told by a medical professional you have:

	Yes	No
a. Alzheimer's disease, any form of cancer (other than basal cell skin cancer), leukemia, liver disease, heart disease, congestive heart failure (CHF), stroke, kidney disease, emphysema, chronic obstructive lung disease (COPD), Amyotrophic Lateral Sclerosis (ALS), Quadriplegia, Progressive Muscular Dystrophy or Atrophy, Progressive Multiple Sclerosis (MS), diabetes (other than diet controlled), or had surgery for heart or circulatory system disorders, or had organ(s) or tissue transplanted, or been diagnosed with a terminal medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 5 years:
 - a. Used any illegal, restricted or controlled substance except as prescribed by a medical professional, or been counseled or treated for alcohol or controlled substance use? Yes No
 - b. Attempted suicide? Yes No
 - c. Been convicted of a felony, imprisoned or on probation? Yes No
3. Answer either a. or b.:
 - a. If you are 5'10" or shorter, do you weigh more than 325 lbs? Yes No
 - b. If you are 5'11" or taller, do you weigh more than 375 lbs? Yes No
4. Have you ever had or been diagnosed or treated by a medical professional for: AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other AIDS-related condition, or received a positive result of an HIV test? Or tested positive or received treatment for hepatitis C? Yes No

Section III. THE RATES FOR THIS TERM INSURANCE PRODUCT ARE BASED ON SMOKING HABITS. PLEASE ANSWER THIS QUESTION FOR CLASSIFICATION PURPOSES:

(To qualify as a nonsmoker, you must not have smoked one or more cigarettes in the last 12 months.)

1. Have you used tobacco in any form in the last 12 months? Yes No
 If "Yes," check all blocks that apply to the kinds of tobacco used:

<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Pipe	<input type="checkbox"/> Cigars	<input type="checkbox"/> Chewing	<input type="checkbox"/> Snuff	<input type="checkbox"/> Dip
<input type="checkbox"/> Rub	<input type="checkbox"/> Patch	<input type="checkbox"/> Other _____			

(Give to customer in all cases, but do **not** complete Receipt unless 1st months premium is received.)

Motorists Life Insurance Company, 471 E. Broad Street Columbus, Ohio 43215 . www.motorists-life.com

CASH RECEIPT

Received from _____ the ____ (day) of _____ (mo.) ____ (yr.), the sum of \$ _____ being the payment of _____ month(s) premium. The insurance applied for shall not take effect until the policy is issued by the Company and the policy is received and accepted by the applicant and first premium paid, during the good health of the proposed insured. In the event the application is declined, any payment made by the applicant will be returned.

Agent's Signature _____ Agent's Telephone Number _____

Make checks payable to Motorists Life Insurance Company. Do not make payable to agent or leave payee blank.

NOTIFICATION OF INVESTIGATIVE CONSUMER REPORT

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with you, your family, friends, neighbors, and associates. Upon written request to the Manager, New Business Department, at the above address, further information on the nature and scope of the report will be provided. No information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Motorists Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Motorists Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTIFICATION OF ANTI-FRAUD LAW TO APPLICANTS APPLYING FOR LIFE INSURANCE

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

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Information for Applicant to Retain

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