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 by a licensed medical doctor as terminally ill, been in hospice, or been committed to or been advised to be committed by a licensed medical doctor to a hospital or nursing home for five or more days? ☐ Yes ☐ No

2) Is the applicant unable to 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, 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

4) Has the applicant been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

If all 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 is not answered, the policy will be issued with a two-year Graded Death Benefit.

Primary Care Physician	Phone #

D. Policy Information

Face Amount: $	Ultimate Death Benefit: $ *For Level Death Benefit policies, multiple Face Amount by 125%*
Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	Base Premium Amount: $
☐ Dependent Child or Grandchild Rider *$5,000 Face amount and separate application required*	Rider Premium Amount: $ *($1.00 per month)*
	Total Premium Amount: $

Spousal Bonus Rider – Full Name and Date of Birth:
$10,000 Face amount and separate application required

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 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 Insured must be alive and in the same health as described above or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the Policy is delivered. 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 might make to the Policy for which I am applying.

Insurable Interest: By signing below, I certify that insurable interest laws are met in the State of Florida.

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 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.

Secondary Lapse Notice: I understand that I can elect another individual to receive mailed notification of an impending lapse in coverage. If provided, GWIC will send the secondary addressee notice at least 21 days prior to the expiration of the grace period. If I elect to have a secondary lapse notice sent, I will fill out and provide separately to GWIC the contact information for the notice.

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.

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)* State License Identification Number

x _____ _____
Agent's Signature Signed on (mm / dd / yyyy)

PREMIUM WITHDRAWAL AUTHORIZATION FORM

(Complete one form per Applicant)

GREAT WESTERN INSURANCE COMPANY
Mail policies to: PO Box 9160 Ogden, Utah 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: *(fill in following if other is checked)*		Relationship
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

Bank Account Information

Financial Institution (Bank Name):

❑ Checking ❑ Savings *(Contact your bank to verify EFT is allowed)*

Routing # (lower left corner of check):

Bank Account # (lower middle of check):

Credit Card Information

Credit Card:

❑ VISA ❑ MASTERCARD ❑ AMEX ❑ DISCOVER

Exp. Date

M	**M**	**Y**	**Y**

CVV

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).

❑ **A one-time initial and ongoing** *(initial will be drawn on: _____/_____/_____ or immediately if left blank)*

❑ Ongoing only

Please select only one box to indicate the date for ongoing withdrawal:

❑ _____ (1-28) ❑ 2nd Wednesday ❑ 3rd Wednesday ❑ 4th Wednesday

Amount of Premium: $

_____

Accountholder/Cardholder's Name *(Please print)*

X _____

Accountholder/Cardholder Signature

_____

Signed on: *(mm/dd/yyyy)*

GWIC GREAT WESTERN INSURANCE COMPANY

Guaranteed Assurance Rate Chart

	Per Unit Face Annual Premiums	
Age	Male	Female
40	56	45
41	57	46
42	59	48
43	61	50
44	62	51
45	63	52
46	64	53
47	65	54
48	67	55
49	67	56
50	68	56
51	69	57
52	69	59
53	70	60
54	72	62
55	74	64
56	76	67
57	79	69
58	81	71
59	84	73

	Per Unit Face Annual Premiums	
Age	Male	Female
60	87	76
61	91	79
62	94	82
63	98	86
64	102	90
65	107	93
66	113	97
67	119	101
68	125	105
69	132	111
70	140	119
71	149	128
72	159	139
73	170	150
74	178	156
75	187	163
76	197	171
77	208	180
78	220	190
79	242	207
80	270	225

Take Face Amount, divide by $1,000;
Multiply by Annual Premium;
Add $35.00 Policy Fee;
Divide by:

- **2** for Semi-Annual Premium
- **4** for Quarterly Premium
- **12** for Monthly Premium

Example:
46 Year Old Female;
Face Amount $15,000; Monthly

$15,000/1,000 = $15.00
$15.00 x 53 = $795.00
$795.00 + $35.00 = $830.00
$830.00/12 = $69.17 Monthly Premium

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.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

Great Western Insurance Company

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

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish to receive a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

YES ☐ NO ☐

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
APPLICANT'S SIGNATURE DATE

_____ _____
AGENT'S SIGNATURE DATE

_____
AGENT'S NAME (PRINTED OR TYPED)

_____
AGENT'S ADDRESS (PRINTED OR TYPED)

_____
AGENT'S COMPANY (PRINTED OR TYPED)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured