Application

Individual Whole Life Insurance

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

aetnaseniorproducts.com

ICC20-CLIFE06194

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100720

Application for Individual Whole Life Insurance

- *Print clearly and use blue or black ink.*
- *Use section 7 for additional remarks, requests, or explanations.*
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512**.

Section 1. Proposed insured information

Proposed insured's name *(first, M.I., last)*

Phone

Residential address *(must be a physical address)*

Apt/suite number

City | **State** | **Zip**

Mailing address *(if different than residential address)*

Apt/suite number

City | **State** | **Zip**

E-mail | **Social Security Number** | **Birth date*** *(mm/dd/yyyy)*

Place of birth *(city, state)* | **Age** | ☐ **Male** ☐ **Female**

Are you a legal resident of the United States? ☐ Yes ☐ No

Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes) ☐ Yes ☐ No

Do you have an existing Medicare Supplement policy with Aetna? ☐ Yes ☐ No

If Yes, what is your policy number?

Section 2. Health questions

If any health questions are answered "yes" in section 2, the applicant(s) will not qualify for this insurance with us.

For the purposes of these questions “you” means the proposed insured. “Diagnosed”, “advised”, “tested” and “treatment” mean by a licensed physician or medical practitioner.

1. Are you dependent on a wheelchair or any motorized mobility device? ☐ Yes ☐ No

2. Do any of the following apply to you? ☐ Yes ☐ No
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy

3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?

A. congestive heart failure, unoperated aneurysm, defibrillator? ☐ Yes ☐ No

B. leukemia, lymphoma, multiple myeloma, cirrhosis? ☐ Yes ☐ No

C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy? ☐ Yes ☐ No

D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease? ☐ Yes ☐ No

E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant? ☐ Yes ☐ No

Section 2. Health questions *continued*

4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?

- **A.** that requires use of insulin? ☐ Yes ☐ No
- **B.** with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage? ☐ Yes ☐ No
- **C.** with history of heart attack or stroke (at any time)? ☐ Yes ☐ No
- **D.** treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar? ☐ Yes ☐ No

5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?

- **A.** alcoholism, drug abuse? ☐ Yes ☐ No
- **B.** cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder? ☐ Yes ☐ No
- **C.** internal cancer, melanoma, Hodgkin's Disease? ☐ Yes ☐ No
- **D.** hepatitis, disorder of the pancreas? ☐ Yes ☐ No

6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?

- **A.** enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease? ☐ Yes ☐ No
- **B.** myasthenia gravis, systemic lupus or connective tissue disorder? ☐ Yes ☐ No
- **C.** osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living? ☐ Yes ☐ No
- **D.** any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder? ☐ Yes ☐ No
- **E.** any lung or respiratory disorder and currently use tobacco products? ☐ Yes ☐ No

7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing (except those tests related to the Human Immunodeficiency Virus [AIDS virus]), or surgery that has not been performed or do you have pending test results? ☐ Yes ☐ No

8. At any time, have you been diagnosed as having or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection? ☐ Yes ☐ No

9. Within the past 12 months, have you been medically diagnosed or treated, or had surgery for a heart attack, artery blockage, or heart valve disorder? ☐ Yes ☐ No

10. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections? ☐ Yes ☐ No

11. Within the past 12 months, do any of the following apply to you?

- **A.** had a pacemaker implanted? ☐ Yes ☐ No
- **B.** had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer? ☐ Yes ☐ No
- **C.** had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer? ☐ Yes ☐ No
- **D.** medically diagnosed as having a seizure? ☐ Yes ☐ No

12. Within the past 12 months, was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic? ☐ Yes ☐ No

Systolic is the upper number and diastolic is the bottom number of a blood pressure reading.

Section 3. Benefits and premium information

Initial amount of insurance applied for
$

Plan requested: Level Plan

Riders requested
☐ Accidental Death Benefit Rider ☐ Children's Term Insurance Rider

Requested effective date* *(mm/dd/yyyy)*

Nonforfeiture options**
☐ Automatic premium loan ☐ Reduced paid-up insurance ☐ Extended term insurance

Initial premium
☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

I would like subsequent payment withdrawn on the _____day of the month **OR** the ☐ 2nd ☐ 3rd ☐ 4th Wednesday of the month.

Initial premium amount
$

Payment mode
☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly (EFT only)

Premium payment method
☐ EFT *(Electronic Funds Transfer)* ☐ Check or money order

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.

**If a nonforfeiture option is not selected, extended term insurance is the default.

Mail policy to: ☐ Applicant ☐ Agent

Payment modes and methods
You have a choice of four payment modes for paying your premium. The Company may charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in available modes and methods and help you decide which is best for you. EFT is an available premium payment method for all payment modes, but EFT is the only premium payment method available for the Monthly payment mode.

Section 4. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. Percent share must total 100%.

Beneficiary name *(first, M.I., last)*	**Relationship to insured**	**Phone**	**Share**
			%
Address	**Social Security Number**	☐ **Primary** ☐ **Contingent**	
Beneficiary name *(first, M.I., last)*	**Relationship to insured**	**Phone**	**Share**
			%
Address	**Social Security Number**	☐ **Primary** ☐ **Contingent**	
Beneficiary name *(first, M.I., last)*	**Relationship to insured**	**Phone**	**Share**
			%
Address	**Social Security Number**	☐ **Primary** ☐ **Contingent**	
Beneficiary name *(first, M.I., last)*	**Relationship to insured**	**Phone**	**Share**
			%
Address	**Social Security Number**	☐ **Primary** ☐ **Contingent**	

Section 5. Replacement information

1. Does the proposed insured currently have any life insurance or annuity in force? ☐ Yes ☐ No

2. Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ☐ Yes ☐ No

If the answer to either question is “yes”, please provide the information below:

Company name	**Face amount**	**Policy number**
.	.	.

Company mailing address *(to send notice of replacement)*

.

Section 6. Health history optional comments *(not required)*

Provide any additional information available regarding underwriting questions (diagnosis, dates, durations, medications, dosages).

Section 7. Remarks

Section 8. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by taking your insurance application, collecting your initial premium and, if applicable, delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- commissions when a policy is purchased or renewed
- fees for marketing and administrative services
- educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Section 9. Applicant agreement

This agreement is to acknowledge that I am applying for an insurance policy from Continental Life Insurance Company of Brentwood, Tennessee that will be issued based on my answers to the questions on this application and information obtained by the company as described below. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the company's administrative office, and made a part of the contract of insurance. An officer of the company is the only one who can make, modify or discharge contracts or waive any of the company's rights or requirements. Any modifications must be documented in writing.

I also understand that, unless otherwise specified in the Temporary Insurance Agreement (Kansas residents only), I do not have coverage until this application is approved, the first full modal premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the company and coverage has become effective.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand and agree that information regarding my insurability will be treated as confidential. Continental Life Insurance Company of Brentwood, Tennessee or its reinsurers may, however, make a brief report of my protected health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. I understand and agree that if I apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. I may contact MIB at 866-692-6901. If I question the accuracy of information in MIB's file, I may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, consumer reporting agency, pharmacy, pharmacy benefit manager, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Continental Life Insurance Company of Brentwood, Tennessee, or its reinsurers, any such information.

A photographic copy of this authorization shall be as valid as the original.

Applicant signature	**Date signed**
X	.
Owner signature* *(if not proposed insured)*	**Date signed**
X	.
Owner Social Security Number	**Signed in** *(city and state)*
.	.

*If owner or payor is different than proposed insured, indicate name, address and relationship to proposed insured in Remarks (section 7).

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.

Section 10. Bank account information

Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment.
Include a voided check with the application.

Account owner name *(if different than proposed insured's)*

•

Account owner relationship to proposed insured

☐ Family member; please specify: .....

☐ Living trust ☐ Employer ☐ Power of Attorney ☐ Conservator/guardian ☐ Business owned by proposed insured

Financial institution name

•

Account type

☐ Checking ☐ Savings

Routing number

☐☐☐☐☐☐☐☐☐

Account number

☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Account owner signature

X

Date signed

•

Section 12. Agent information

I certify that:

1. The insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

Does the proposed insured have any existing life insurance or annuity contracts? ☐ Yes ☐ No

Will the policy applied for be a replacement or change existing life insurance or an annuity? ☐ Yes ☐ No

If the answer to either question is "yes", have you complied with the requirements of the company and your state regarding this replacement? ☐ Yes ☐ No

All information must be completed. The writing number reflects where commissions will be paid.

Agent name *(printed)*

Writing number *(agent or company)*

Agent signature

X

Phone

Email

Section 13. Agent request to split commissions

If this application results in an issued policy through Continental Life Insurance Company of Brentwood, Tennessee (CLI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with CLI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective CLI commission schedule.

Writing agent name *(printed)*

Percentage

%

Writing agent signature

X

Secondary agent

Writing number

Percentage

%

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.