LIFE ASSURANCE COMPANY, INC.
P. O. BOX 20667
OKLAHOMA CITY, OK 73156
(405) 810–1111 OK 1–800–522–1314
FAX (405) 810–1122

APPLICATION FOR INSURANCE

NAME OF PROPOSED INSURED		SS#	POLICY NUMBER
ADDRESS	ZIP CODE	OCCUPATION (JOB TITLE)	
OWNER OF POLICY IF OTHER THAN INSURED		EMPLOYER'S NAME AND ADDRESS	

☐ MALE ☐ FEMALE	DATE OF BIRTH	AGE	STATE OF BIRTH	HEIGHT	WEIGHT	HOME PHONE #	BUSINESS PHONE #

TYPE OF PLAN	AMOUNT OF INSURANCE	NO. OF YEARS	PREMIUM			
☐ AP SPT	$			☐ PREPAID	☐ SEMI ANNUAL	☐ MONTHLY BANK DRAFT
☐ AP 15				☐ ANNUAL	☐ QUARTERLY	
☐ _____						

PRIMARY BENEFICIARY (OTHER THAN CREDITOR) — RELATIONSHIP

CONTINGENT BENEFICIARY — RELATIONSHIP

	YES	NO
1. a. Have you ever had or do you now have heart disease, stroke, high blood pressure, diabetes, cancer, lung, kidney, stomach and intestinal tract or liver disease, paralysis, alcoholism, drug addiction, or mental condition?	☐	☐
b. Are you now taking medication or receiving medical attention?	☐	☐
c. An immune deficiency disorder, AIDS or the AIDS related complex (ARC)?	☐	☐
d. Have you been confined in the last 5 years to a hospital or sanitarium or seen a doctor for any reason other than stated in part a? *If "Yes" to any part of Question 1, give full details below*	☐	☐

Question #	Condition	Dates	Treatment	Name & Address of Doctors, Hospitals or Clinics Consulted

	YES	NO
2. Have you in the last three years been or intend to become an aviation pilot, crew member or non-fare paying passenger? (If yes, please complete aviation questionnaire & attach to application.)	☐	☐
3. Have you smoked cigarettes in the last 12 months?	☐	☐
4. Is this insurance intended to replace or modify any insurance with this or any other company?	☐	☐

LAAP 3–02

CONTINUED ON BACK

CONDITIONAL RECEIPT FOR FIRST PREMIUM FOR POLICY AMOUNTS BELOW $200,000

Received from _____ and _____

the sum of $ _____ on _____, 20____

UNLESS THE CONDITIONS STATED BELOW ARE FULFILLED, NO COVERAGE SHALL TAKE EFFECT PRIOR TO DELIVERY OF THIS POLICY AND THIS PAYMENT WILL BE REFUNDED. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.

CONDITIONS UNDER WHICH THIS PAYMENT SHALL CAUSE CONDITIONAL COVERAGE TO TAKE EFFECT

1) All persons proposed for insurance must be insurable to Life Assurance Company under its rules as standard risk for the requested insurance on the later of: (a) the date of application, or (b) the date of completion of all medical tests and examinations required by Life Assurance Company. 2) Any check given for payment must be honored on first presentation.

WHEN CONDITIONAL COVERAGE BEGINS

If the conditions listed above are fulfilled, then the amount of conditional coverage specified below shall take effect on the later of: 1) the date of application, or 2) the date of the completion of all medical tests and examinations required by Life Assurance Company.

GIVE TO APPLICANT

NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for your application for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells you how information is gathered to review your application.

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. The Authorization you signed will allow us to obtain this information and share it with others when necessary. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may be disclosed to others without your further consent.

You have the right to review and to correct this information, and you have a right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to Underwriting Department, Life Assurance Company, P. O. Box 20667, Oklahoma City, Oklahoma 73156.

GIVE TO APPLICANT

HOME OFFICE CORRECTIONS AND AMENDMENTS ONLY

REMARKS

ASSIGNMENT: For Value received, I Hereby Assign to _____ Assignee, any payments and refunds due under the above applied for Life Insurance Policy when issued to the extent of any indebtedness due by me to said Assignee.

IT IS AGREED: (1) That all statements in this application, are, to the best of my knowledge and belief, complete and true, and, (2) that this application and any amendments attached to it with the answers made to the medical examiner, if required, will be the basis of any insurance issued; (3) that all information given to the agent as shown on this application is correct as shown; (4) that no agent can accept risks, change the policy, or waive any rights or requirements of the Company; (5) that unless it is stated in a conditional receipt dated the same date as this application, the Company will not be liable until a policy is delivered to and accepted by the Owner and the first premium is paid during the lifetime and good health of the person proposed for coverage under a life policy (including accidental death).

The proposed insured (parent or guardian, if a minor) states that they have been given and have read the notice relating to the Medical Information Bureau and the Federal Fair Credit Reporting Act.

The acceptance of any policy issued on this application will be deemed an acceptance and ratification of any corrections, additions or changes made by the Company in the space labeled: "Home Office Corrections and Amendments Only" except that in those states which require that any change in amount, classification, plan of insurance or benefits must be done by the written ratification of the applicant.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give the Life Assurance Company or its Reinsurers any such information. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records of knowledge to any agency employed by the insurance company to collect and transmit such information. A photographic copy of this authorization shall be as valid as the original. **Notice: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated while a patient here.**

Signed at _____ (City) _____ (State) this _____ day of _____, 20 _____.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

X _____ _____

Signature of Proposed Insured | Signature of Owner (if other than Insured). If corporate owned, obtain signature of alternate officer.

For Agent: Do you have any knowledge or reason to believe that replacement of existing insurance or annuities may be involved? ☐ Yes ☐ No

Name of Agent (please print)_____

_____ _____ _____

Signature of Agent | Agent Number | Agency Number

WHEN CONDITIONAL COVERAGE ENDS

Conditional coverage if any, ends on the earliest of the following dates: 1) the date Life Assurance Company issued the policy as applied for, or 2) 90 days after the date of this receipt.

AMOUNT OF CONDITIONAL LIFE INSURANCE COVERAGE

If conditional coverage becomes effective under the terms of this receipt, then the amount of conditional life insurance coverage on any person proposed for insurance is the lesser of 1) the amount of life insurance applied for, or 2) $200,000 reduced by any life insurance or accidental death benefits then in force or pending with Life Assurance Company.

Agent's Signature _____

"ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK." **LIFE ASSURANCE COMPANY, INC., P. O. BOX 20667, OKLAHOMA CITY, OK 73156.**

MEDICAL INFORMATION BUREAU NOTICE

We or our reinsurers may make a brief report to the Medical Information Bureau (MIB). The MIB is a nonprofit organization of life insurance companies. It is an information exchange for its members. If you apply to a MIB member company for life or health insurance, or file a claim with such a company, the MIB, upon request, will give the company the information in the MIB's file.

Upon receipt of a request from you, the MIB will give you any information it may have in your file. Medical information may be disclosed only to your physician. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction under the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is (617) 426–3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim may be submitted.

FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. The reports contain information about your character, general reputation, personal characteristics, mode of living and health. The information may be obtained through interviews with you, your neighbors, friends and others who know you. Upon request, we will disclose to you whether or not such a report was made. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

MEDICAL/MIB AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, pharmacy benefits manager, hospital, clinic or other medical or medically related facility, insurance company, the MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give the Life Assurance Company or its Reinsurers any such information. I authorize Life Assurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. To facilitate rapid submission of such information, I authorize all said sources, except the MIB to give such records of knowledge to any agency employed by the insurance company to collect and transmit such information. A photographic copy of this authorization shall be as valid as the original This authorization will be valid for 12 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by Life Assurance Company or its reinsurers while this authorization is in force. **Notice: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/Aids (Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated while a patient here.**

Signed at _____this _____day of _____, 20_____

City State

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELON.

X_____ _____

Signature of Proposed Insured Signature of Owner (if other than insured) If corporate owned, obtain signature of alternate officer

For Agent: Do you have any knowledge or reason to believe that replacement of existing insurance or annuities may be involved? ____ yes ____ no

Name of Agent (please print) _____

_____

Signature of Agent

MIB PRE-NOTICE

We, or our reinsurers, may make a brief report to the MIB, Inc. (MIB). MIB, Inc. is a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to a MIB member company for life or health insurance coverage, or file a claim with such a company, the MIB, upon request, will give the company the information in the MIB's file. Upon receipt of a request from you, the MIB will give you any information it may have in your file. Medical information may be disclosed only to your physician. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction under the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com. We or our reinsurers may also release information in our file to other insurance companies to whom you may apply for life or health insurance or to whom a claim may be submitted.

FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. The reports contain information about your character, general reputation, personal characteristics, mode of living and health. The information may be obtained through interviews with you, your neighbors, friends and others who know you. Upon request, we will disclose to you whether or not such a report was made. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.