SUPPLEMENTAL APPLICATION FOR CREDIT INSURANCE

Life Assurance Company, Inc.
P.O. Box 20667
Oklahoma City, OK 73156
405-810-1111
OK 1-800-522-1314

1. _____
   Full Name of Insured **Address of Insured**

2. _____
   Month-Day-Year Birth **Place of Birth** **Occupation**

3. $_____
   Face Amount **Plan (Level/Decreasing)** **Term No.** **Premium** **Effective Date**

4. (a) _____
   Primary Beneficiary-Creditor

   (b) _____
   Secondary Beneficiary **Relationship**

5. Have you been, or are you now, or do you intend to participate in non-scheduled aircraft flights? Yes ☐ **No** ☐

6. Height? _____ Weight? _____ Has your weight changed in the past year? Yes ☐ **No** ☐ Gained _____lbs; Lost _____lbs.

QUESTION 7 MUST BE ANSWERED IN ALL CASES

	YES	**NO**
7. a. Have you ever had or do you now have Coronary Artery Disease, Congestive Heart Failure, Cancer; Diabetes, High Blood Pressure, Epilepsy, Stroke, Chronic Muscle Disease, Depression, Cirrhosis, COPD, Leukemia, Alcohol or Drug Addiction, Acquired Immune Deficiency Syndrome (AIDS) or the Aids Related Complex (ARC) or tested positive for HIV?	☐	☐
b. Are you now taking medication or receiving medical attention?	☐	☐
c. Have you been medically treated or diagnosed with Carpal Tunnel or Disorder of the Back, Spine, Shoulder, Neck, Knee, or Fibromyalgia?	☐	☐
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 (item a) and/or (item c)? If "Yes" to any part of Question 7, give full details below	☐	☐

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

Your CLAIM MAY BE DENIED if your Application for this insurance contains incomplete or inaccurate information.

To the best of my knowledge, the answers shown above are full and true. I further understand and agree that: (1) This Application is subject to final acceptance or rejection by the Company; and (2) This Application forms a part of any certificate of insurance issued because of this Application and (3) If the insurance is not accepted by the Company the Debtor shall be notified within 40 days and all premiums paid will be refunded to the Debtor.

I agree that the following may give the Life Assurance Company or its reinsurers information relating to my health: (1) Any licensed physician (2) Medical practitioner; (3) Hospital; (4) Clinic; (5) any other medical and medically related facility; (6) Insurance companies; and any (7) Other organization, institute or person that has any record of knowledge of me or my health. A copy of this authorization is as valid as the original. I further understand and acknowledge that the information authorized for release may include information, which may be considered a communicable, or venereal disease, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and Human Immunodeficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS).

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.

I (we) hereby certify that the answers on this application form are true, accurate and correct. **IMPORTANT! YOUR COVERAGE CAN BE DENIED IF ANY ANSWER TO THE ABOVE HEALTH QUESTIONS IS INACCURATE, MISTAKEN, OR INCOMPLETE.**

_____ _____

AGENT SIGNATURE OF PROPOSED INSURED

DATE _____