OFFICER #_____

MOUNTAIN LIFE INSURANCE COMPANY
P.O. Box 240 Alcoa, TN 37701-0240

POLICY # **(HOME OFFICE USE ONLY)**

TERM LIFE INSURANCE APPLICATION

PRIMARY INSURED

FULL NAME			SEX	HEIGHT	WEIGHT
ADDRESS			DATE OF BIRTH/ STATE		AGE
CITY	STATE	ZIP	HOME PHONE ( ) -	BUSINESS PHONE ( ) -	SOC. SEC. # - -
EMPLOYER			OCCUPATION		

JOINT INSURED

FULL NAME			SEX	HEIGHT	WEIGHT
ADDRESS			DATE OF BIRTH/ STATE		AGE
CITY	STATE	ZIP	HOME PHONE ( ) -	BUSINESS PHONE ( ) -	SOC. SEC. # - -
EMPLOYER			OCCUPATION		

SINGLE PREMIUM

LEVEL SINGLE ☐ JOINT ☐

DECREASING SINGLE ☐ JOINT ☐

OR

ANNUAL PREMIUM

MORTGAGE PROTECTION SINGLE ☐ JOINT ☐

LEVEL PREMIUM SINGLE ☐ JOINT ☐

ANNUAL RENEWABLE SINGLE ☐ JOINT ☐

METHOD OF PAYMENT

ANNUAL ☐
SEMI-ANNUAL ☐
QUARTERLY ☐
MONTHLY PAC ☐
PREPAID_____ YRS ☐

INITIAL FACE AMOUNT $_____

TERM IN YEARS _____

PREMIUM $_____

BENEFICIARY (WITH RIGHT TO CHANGE) PRINT FIRST NAME, MIDDLE INITIAL, AND LAST NAME. | RELATIONSHIP

HEALTH INFORMATION

	PRIMARY YES	PRIMARY NO	JOINT YES	JOINT NO
1. During the past ten years have you been treated for or advised by a licensed physician that you had any of the following: disease or disorder of the heart, blood, lungs, liver, or kidneys; any mental, nervous, circulatory, or digestive disorder; high blood pressure; cancer or tumor; diabetes; drug or alcohol abuse; AIDS, ARC (AIDS Related Complex), or tested positive on an AIDS related blood test?	☐	☐	☐	☐
2. Other than those conditions covered in question 1, during the past five years, have you consulted a doctor, or other health care provider or been hospitalized?	☐	☐	☐	☐
3. Have you ever or do you ever intend to pilot an aircraft, scuba dive, race motor vehicles, skydive, or participate in any other similar activity or sport?	☐	☐	☐	☐
4. Have you smoked cigarettes, cigars, or pipe tobacco within the past twelve months?	☐	☐	☐	☐

IF YES, GIVE DETAILS. (INDICATE REASONS, DATES, NAMES, PHONE NUMBERS AND/OR ADDRESSES OF DOCTORS.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, 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 to the Mountain Life Insurance Company, or its reinsurer(s), any such information. I understand that Mountain Life Ins. Co. or its reinsurer(s) will use this information to determine eligibility for insurance. I agree this Authorization is valid for two and one half years from the date signed. I know that I have a right to receive a copy of this Authorization upon request. I agree that a photographic copy of this Authorization is as valid as the original. I acknowledge receipt of the Notice of Information Practices, including the notices explaining my rights under the Fair Credit Reporting Act as it pertains to investigative consumer reports and the Medical Information Bureau.

I have read and agree to all the terms and conditions on the "Authorization to Obtain Information" above and the "Agreement" located on the reverse side of this form.

To the best of my knowledge, the insurance applied for in this application will ☐ will not ☐ replace existing insurance or annuities.

Primary Insured _____ **Joint Insured** _____

To the best of my knowledge, the insurance applied for in this application will ☐ will not ☐ replace existing insurance or annuities.

Agent_____ **Dated** _____**At**_____

GA-TL-1101-APP

MOUNTAIN LIFE INSURANCE COMPANY

AGREEMENT AND NOTICE OF INFORMATION PRACTICES

AGREEMENT

It is understood and agreed that:

1. I have carefully read the statements and answers in this application. They are, to the best of my knowledge and belief, true and complete. They and the answers to any required medical examination will become a part of this application and any policy issued on it.
2. No agent has the authority to waive the answer to any question, to determine insurability, to waive any of the company's rights or requirements, or to make or alter any contract or policy.
3. For applicants seeking coverage in the amount of $300,000 or less and a premium deposit is tendered; the insurance applied for will only take effect when the Proposed Insured is found to be a standard risk under the Mountain Life Insurance Company rules; all medical tests and examinations are completed; the policy is delivered; and the first premium is paid in full; while the health of the Proposed Insured remains as stated in the application and during the Proposed Insured's lifetime.
4. On applications seeking coverage in excess of $300,000, no advance premium deposit will be accepted and no insurance will take effect unless all medical tests and examinations are completed; the Proposed Insured is found to be a standard risk under the Mountain Life Insurance Company rules (or rated coverage is offered by Mountain Life Insurance Company and accepted by the Proposed Insured); the policy is delivered; and the first premium is paid in full while the health of the Proposed Insured remains as stated in the application and during the Proposed Insured's lifetime.

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and M.I.B., Inc. Notice

We thank you for your application. It is the major source of information about you, which we use in evaluating your application and reviewing your policy. However, we wish to inform you that we may order an investigative consumer report as to your insurability. If an investigative consumer report is prepared concerning this application, you may request an interview concerning the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether we ordered such a report, we will be pleased to furnish this information, upon your written request to our Home Office. You may also receive additional information as to its nature and scope, including the name, the address and the telephone number of the reporting agency. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We usually will not disclose information about you without your prior written authorization. However, in certain situations we may disclose some of this information about you to third parties having a business interest in an insurance transaction involving you, or having a contract with us to perform part of our insurance function. This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office. Please mail your written request to the address in the box below.

M.I.B., Inc. Notice

Mountain Life treats the information you provide to us regarding your insurability as confidential. Mountain Life, or its reinsurer(s), may make a brief report thereon to the Medical Information Bureau. The Medical Information Bureau is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure 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. MIB can be reached by telephone at (866) 692-6901 (TTY (866) 346-3642) or through the www.mib.com website. Information for consumers about MIB may be also obtained through the website.

We (and/or our reinsurer(s)) may also release information in our file to our reinsurer(s) and to other life insurance companies to whom you apply for life or health insurance or to whom you have submitted a claim for benefits.

To obtain further information contact:
Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

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P.O. Box 240
Alcoa, TN 37701-0240

ASSIGNMENT

FOR VALUE RECEIVED, I hereby assign and transfer to _____ _____ its successors and assigns, the policy issued by Mountain Life Insurance Company and all claims, options, privileges, rights, title and interest therein, with the exception of the right to designate and change the beneficiary. This assignment is made as collateral security for any and all liabilities of the undersigned to the assignee. The sole signature of the assignee shall be sufficient for the exercise of any rights under the policy assigned hereby and the sole receipt of the assignee shall be a full discharge and release therefore to Mountain Life Insurance Company.
Signed and sealed this _____day of _____ , _____

_____ _____
Witness **Proposed Insured's Signature**

GA-OL-0897-PA

MOUNTAIN LIFE INSURANCE COMPANY
P.O. Box 240
Alcoa, Tennessee 37701-0240
800-888-6542

Medical Records Release Authorization

Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

Circle the purpose(s)

1) **Determining eligibility for insurance;**

2) **Determining benefits payable on a disability claim;**

3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

This Authorization will expire on _____, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).

_____ _____
Signature of Individual Whose Information is to be Disclosed or Authorized Representative **Date of Birth**

_____ _____
Print Name of Individual **Date**