OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

TERM MADE SIMPLE

INDIVIDUAL LIFE INSURANCE APPLICATION (Please print in black ink)

Telephone Case No:

Proposed Insured: _____
(First) (Middle) (Last)

Address: (No. & Street) _____

City: State: Zip Code:

Telephone interview done (if applicable) ☐ Yes ☐ No

_____ _____ ☐ am ☐ pm
Phone Best time to call

E-mail Address @

Sex	Date of Birth	Age	State of Birth	SS#	DL#	Height	Weight
☐ Male ☐ Female	Mo. Day Yr / /			— —	State of Issue	ft in	lbs

Occupation/Duties: Hire date (MM/YY): Annual Salary: $

Owner: Name _____ SS# _____ Address: _____

Payor: Name SS# Address:

Primary Primary Beneficiary _____ SS# _____ Relationship _____

Insured: Contingent Beneficiary SS# Relationship

Plan: _____ **Face Amount $** _____ ☐ Non-Tobacco ☐ Tobacco ☐ Preferred Non-Tobacco

Have you used tobacco or nicotine products in any form in the past 12 months? ☐ Yes ☐ No.....or during the past 36 months? ☐ Yes ☐ No

Riders: ☐ Waiver of Premium ☐ Unemployment Rider ☐ Other: _____
☐ Critical Illness % ☐ Child Rider (Units): (complete Form No. 3215) ☐ ADB $

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $

CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $

Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Policy Date Request: / /

Physician: Name: City/State Phone:

List current prescribed medications:

SECTION A: Health Questions-Answer Questions 1 through 4 for Proposed Insured. ***(circle all conditions that apply)***

1. **Within the past 10 years,** have you been treated for, or tested positive for, or been diagnosed by a medical professional with:
   a. high blood pressure, high cholesterol, heart attack, angina (cardiac chest pain), angioplasty, bypass surgery or stent, pacemaker or defibrillator, cardiomyopathy, congestive heart failure (CHF), irregular heartbeat, peripheral vascular disease (PVD), carotid artery disease, or any heart or circulatory disease or disorder? ☐ Yes ☐ No
   b. stroke, transient ischemic attack (TIA), amputation caused by disease, aneurysm, hemophilia, or anemia? ☐ Yes ☐ No
   c. diabetes, cirrhosis, hepatitis, pancreas disorder, Crohn's disease, ulcerative colitis, or any digestive or liver disease or disorder? ☐ Yes ☐ No
   d. asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or any respiratory or lung disease or disorder? ☐ Yes ☐ No
   e. cancer in any form, Hodgkin's disease, leukemia, lymphoma, multiple myeloma, or organ transplant? ☐ Yes ☐ No
   f. migrane headaches, seizures, bi-polar disorder, schizophrenia, Alzheimer's, memory loss, dementia, anxiety or depression, mental retardation, mental incapacity, mental or nervous disorder, psychiatric disorder, or a suicide attempt? ☐ Yes ☐ No
   g. any disease or disorder of the kidneys, urinary bladder, prostate, breast, reproductive organs, or sexually transmitted disease? ☐ Yes ☐ No
   h. connective tissue disease, systemic lupus (SLE), multiple sclerosis, Parkinson's, cerebral palsy, muscular dystrophy, cystic fibrosis? ☐ Yes ☐ No
   i. arthritis, paralysis of two or more extremities or any disorder of the back, joints, muscles, or nervous system? ☐ Yes ☐ No
   j. any other disease or disorder, injury, surgery, birth defect, or deformity? ☐ Yes ☐ No
   k. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency related disorder or the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
2. Are you currently unemployed due to medical reasons or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or are you currently receiving benefits, compensation, or pension for disability? ☐ Yes ☐ No
3. Are you currently hospitalized, confined to a nursing facility, receiving Hospice Care or home health care, or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ☐ Yes ☐ No
4. **Within the past 12 months,** have you:
   a. consulted a medical professional, had surgery, or been hospitalized, or had diagnostic tests (excluding HIV/AIDS) such as EKG, Xray, MRI, CAT scan? ☐ Yes ☐ No
   b. had any diagnostic testing (excluding HIV/AIDS), surgery, or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received, or been referred to a medical professional? ☐ Yes ☐ No
   c. been declined, postponed, rated, or modified for life or medical insurance? ☐ Yes ☐ No

SECTION B: Give details to all "Yes" answers in Section A and list current medications (use COMMENTS section on back for additional space).

Condition	Dates	Treatment	Name/Address/Phone No. of Physician/Hospital
	/ /		
	/ /		
	/ /		
	/ /		

Form No. ICC15-OL3188

SECTION C: Answer Questions 1 through 5 for Proposed Insured. ***(circle all conditions that apply)***

1. Have you had a natural parent or sibling diagnosed or treated by a licensed medical professional for diabetes, kidney disease, require a major organ transplant, or been medically diagnosed with heart disease, cerebrovascular disease, internal cancer prior to age 60? (If yes, list in COMMENTS section: name, relationship, age at onset, medical condition, age if living or age at death.) ..... ☐ Yes ☐ No
2. a. **Within the next 24 months,** do you intend to work, travel, or reside outside of the U.S. for more than 30 days? ..... ☐ Yes ☐ No
   If yes, where?_____
   b. **Within the past 24 months,** have you made or contemplated making any flights as a pilot, student pilot, or crew member of any aircraft? ..... ☐ Yes ☐ No
3. a. **Within the past 5 years,** have you pled guilty to or been convicted of a felony or misdemeanor (including DUI or DWI) or do you have such charge currently pending against you or have you had a driver's license suspended or revoked or is currently suspended or revoked, any motor vehicle violations or **within the past 6 months,** have you been on probation or parole? ..... ☐ Yes ☐ No
   b. **Within the past 5 years,** participated in motorized racing, hang gliding, rock or mountain climbing, rodeo events, sky diving, or skin or scuba diving? ..... ☐ Yes ☐ No
4. **Within the past 10 years,** have you used illegal drugs, or abused alcohol or drugs, or had or been recommended by a medical professional or a licensed counselor to discontinue the use of alcohol or drugs or to have treatment or counseling for alcohol or drugs? ☐ Yes ☐ No

5. Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No	Company
Will you replace an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No	Policy # Coverage Amount $

COMMENTS:_____

_____

_____

_____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. 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.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or other organization that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this authorization shall be as valid as the original.

CERTIFICATION—I hereby certify, under penalties of perjury, that (1) the social security number indicated above is my correct taxpayer identification number and (2) that I am not subject to backup withholding under Section 3406 (a) (1) (c) of the Internal Revenue Code. The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

I acknowledge receiving the Fair Credit Reporting Act Notice and the MIB, Inc. Pre-Notice. I acknowledge receiving the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness Accelerated Benefit Rider Disclosure Form, the Accelerated Benefit Rider-Confined Care Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms if applicable.

Signed at (City)_____(State)_____ Date of Application (MM/DD/YY) _____

_____ _____

SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Accelerated Living Benefit Rider Disclosure Form, the Terminal Illness Rider Disclosure Form, the Confined Care Accelerated Benefit Rider and Chronic Illness Accelerated Death Benefit Rider Disclosure Forms have been presented to the applicant, if applicable.

Agent's Remarks:_____

Does the proposed insured have any existing life or disability insurance or annuity contract? ..... ☐ Yes ☐ No
Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity? ..... ☐ Yes ☐ No
Has the proposed insured applied for any life insurance or annuity in the last ninety (90) days? ..... ☐ Yes ☐ No

Agent Signature _____ Agent Printed Name_____ No: _____%_____

Agent Signature _____ Agent Printed Name_____ No: _____%_____

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT. THIS RECEIPT SHALL BE INVALID AND MAY NOT BE ISSUED WITH RESPECT TO PROPOSED PAYMENT OF THE INITIAL PREMIUM TENDERED BY MEANS OF A POST-DATED CHECK.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from_____ the sum of $_____as first payment on this application for

Proposed Insured_____Date_____Agent_____

If (1) an amount equal to the first full premium is submitted or a payroll deduction authorization,a government allotment authorization, or a bank draft authorization has been fully implemented in an amount sufficient to pay the first full monthly premium, (2) any check or bank draft authorization given in payment of the initial premium is honored when first presented, (3) all underwriting requirements, including any medical examinations required by the Company's rules, are completed, and (4) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date the payroll deduction authorization or government allotment authorization is submitted for processing, or (c) the requested draft date specified in the bank draft authorization, or (d) the date of the latest medical exam required by the Company. THE TOTAL AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $150,000.00. (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met exactly, the liability of the Company shall be limited to the return of any amount paid.

NOTICE
Printed in compliance with Public Law 91-508

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Occidental Life Insurance Company of North Carolina, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Occidental Life Insurance Company of North Carolina, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE STATEMENT

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider are not intended to qualify for favorable tax treatment. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor. The acceleration-of-life-insurance benefits do not, and are not intended to, qualify as long-term care insurance.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

The Terminal Illness Accelerated Death Benefit Rider attached to your Policy allows you to receive up to 100% of the Death Benefit proceeds of the Policy when the Insured has a medical condition that reasonably can be expected to result in death within 24 months or less. Upon receipt of proof satisfactory to the Company of the Insured's reduced life expectancy and written consent of any assignee or irrevocable beneficiary we will pay an accelerated benefit. It will be paid in a lump sum. It is payable only once.

The Benefit to be paid will be reduced by an Actuarial Adjustment Factor and an Administrative Charge of $150. We will deduct from the Benefit paid any outstanding indebtedness, but only in proportion to the percentage of Death Benefit paid. We will also return to you a proportionate amount of any premium paid beyond the date any Benefit under this Rider is paid. The Cash Value, the amount available for loans and the premium, excluding the Policy fee, for the Policy will decrease in proportion to the amount of Benefit paid. Continued payment of the reduced premium is necessary for the Policy to remain in force. If the entire Death Benefit is paid, then the Policy will terminate with no further value.

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
WACO, TEXAS

DISCLOSURE FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

This summary of coverage briefly highlights some of the major provisions of the Chronic Illness Accelerated Death Benefit Rider. The details of the rights and obligations of all parties under the Rider as well as any limitations or restrictions are set forth in the Rider document.

TAX IMPLICATIONS. The acceleration-of-life-insurance benefits offered under this Rider are not intended to qualify for favorable tax treatment. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor. The acceleration-of-life-insurance benefits do not, and are not intended to, qualify as long-term care insurance.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

READ YOUR RIDER CAREFULLY

Rider Description: The request for the benefit under the Rider must be in writing signed by the Owner. The Owner may make one (1) claim per calendar year. If the Rider is exercised, this may impact the later ability to exercise another Accelerated Death Benefit rider. The Accelerated Death Benefit Payment will be paid in a lump sum.

The Rider allows the Owner to receive payment of a portion of the death benefit under the Policy upon chronic illness of the Insured. The Owner must provide written evidence from a licensed Physician that the Insured has been certified as;

1) Being unable to perform at least two activities of daily living for at least 90 days, as defined in the Rider; or
2) Requiring substantial supervision due to severe cognitive impairment for at least 90 days, as defined in the Rider.

Premium Charge: There is no separate premium charge for the Accelerated Death Benefit Rider.

Administrative Charge: There is an administrative charge of $150 for the exercise of the Rider. This is due at the time of benefit payment.

Amount of Accelerated Death Benefit Payment: The request for a benefit under the Rider must specify the amount of the Policy Death Benefit to be accelerated, subject to the terms in the Rider. The Maximum Acceleration Percentage is 95%. The Maximum Accelerated Death Benefit is $150,000. The actual payment will be a discounted value of the accelerated death benefit minus administrative charge. The discounted value, calculated at the time of claim, will take into account the medical condition of the Insured, required future premiums under the base policy, and the applicable interest rate at the time of claim. If future premiums are expected to increase significantly, this could further lower the actual payment.

Additional Information:

- Accelerated Death Benefits are paid as a lump sum.
- In the event that the Insured dies after a written request for an Accelerated Death Benefit is submitted but before payment is made and we receive written notice at our home office of this death, the request for an Accelerated Death Benefit will be considered void and no benefit will be paid under the Rider.
- Once an Accelerated Death Benefit has been paid, the election to request such Accelerated Death Benefit cannot be revoked.
- Consent of an assignee or irrevocable policy beneficiary may be required.

Effect on Policy: After payment of an Accelerated Death Benefit, the Policy Face Amount, Cash Value, and the amount available for loans will be reduced on a proportional basis. Base policy premiums payable will also be reduced accordingly. There will be no reduction in the annual policy fee.

Government Benefit Eligibility: You should note that the actual or constructive receipt of payment under the rider may adversely affect your eligibility for Medicaid, Supplemental Security Income, or other government benefits or entitlements. Exercising the option to accelerate benefits and receiving those benefits before application for these programs, or while benefits are being received, may affect initial or continued eligibility; an elder law or elder care advisor should be consulted.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Occidental Life Insurance of North Carolina (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: Any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave, Waco TX 76701.

7. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

8. This authorization will expire 24 months after the date signed.

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

Occidental Life Insurance Company of North Carolina

Please note charge may appear on statement under American-Amicable Group of Companies

P.O. Box 2549 Waco TX 76702-2549

Bank Draft Authorization - Please Attach a Voided Check.

The Company indicated above is authorized to initiate debit entries to the account indicated below, and the Bank named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the bank will have a reasonable opportunity to act on such notification. By signing below, I authorize the Company indicated above and/or their representative to receive information from the banking facility named so my account number and routing number may be verified.

Bank Name _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** ☐ Checking ☐ Savings

Account Number _____ **Amount $** _____

Would you like your draft to coincide with your Social Security payment schedule? ☐ Yes ☐ No

Please choose one of the following as your requested draft date (applies to first and future drafts of this account):

☐ Requested Draft Date, If Any (1st-28th) _____ OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

_____ _____

SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) **DATE**

Bank Account Verification - Complete ONLY in absence of void check.

I have verified that the above account is a valid account and can be drafted for insurance premiums. I understand that if the information provided is found to be falsified, I may be subject to disciplinary action up to and including termination of my agent contract. This information was verified by a verification call with a bank representative.

Please provide the phone number and name of the person you spoke to at the Bank:_____

_____ _____

AGENT SIGNATURE / AGENT NUMBER **DATE**

By signing below, I authorize the Company indicated above and/or one of their representatives to receive information from the banking facility named above so my banking information can be verified.

_____ _____

SIGNATURE (of bank account holder) **DATE**

E-Check Bank Draft Authorization
COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

Immediately upon receipt of My Application, please draft $_____ from my account listed above and identified with a void check, deposit slip, bank statement or Bank Account Verification above.

_____ _____

SIGNATURE **DATE**

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA

P.O. Box 2595, Waco, TX 76702-2595

ADDENDUM TO INDIVIDUAL LIFE INSURANCE APPLICATION

Application Addendum Forming a Part of my Application for Insurance

CHILDREN'S INSURANCE AGREEMENT-CIA

Primary Proposed Insured Name (Print): _____

CHILDREN'S COVERAGE ONLY Children Proposed for Insurance:

Proposed Insured Name	Ht.	Wt.	Sex	Birthdate

CHILDRENS HEALTH INFORMATION—To the best of your knowledge and belief, have any of the children listed above for coverage been treated for or told by a medical professional that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or within the past 12 months been hospitalized for asthma or any respiratory disorder?..... ☐ Yes ☐ No

If answered yes to the CHILDRENS HEALTH INFORMATION, please list the names of the children that your answer applies. **These children are excluded from the Children's Insurance Agreement Rider.**

Children Excluded for "Yes" answer: _____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: To the best of my knowledge and belief, all answers and statements contained in this application addendum are true, complete and correctly recorded.

I hereby agree that this amendment shall be an amendment to and form a part of my application for insurance, and be a part of any contract of insurance issued on the basis of such application.

Signed at _____ Application Date _____

CITY STATE MONTH DAY YEAR

_____ _____

SIGNATURE OF PRIMARY PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

_____

WITNESS-LICENSED AGENT SIGNATURE