TERM LIFE

Regular Mail:
United Home Life Insurance Company
P.O. Box 7192
Indianapolis, IN 46207-7192

FAX Number: 317-692-7711
Telephone: 800-428-3001

Overnight Mail:
(FedEx or UPS Recommended)
United Home Life Insurance Company
225 South East St.
Indianapolis, IN 46202

_____ # pages including cover

Fax only once.

Agent Name: _____ Agent #: _____

Agent Phone: _____ Agent Fax: _____

Agent Email Address: _____

How do you prefer to be notified if we should need any underwriting requirements?

☐ E-Mail ☐ Fax

Proposed Insured's Name: _____

Do you personally know the Proposed Insured? ☐ Yes ☐ No

Have you written insurance on the Proposed Insured in the past three (3) years? ☐ Yes ☐ No

Did you personally see all persons proposed for insurance and personally view a photo ID (driver's license, passport) of the Owner and/or Proposed Insured? ☐ Yes ☐ No

If No, how was the application taken?

Solicited by: ☐ Mail ☐ Phone ☐ Internet ☐ Fax ☐ Other _____
(Explain)

Did you identify any unusual behavior or suspicious activity by the Owner or Proposed Insured? ☐ Yes ☐ No

If Yes, please explain. _____

_____

Special Instructions you want us to know: _____

_____

_____

_____

_____

MAIL POLICY TO: ☐ Owner ☐ Agent

Personal History Interviews (PHIs):

Option 1 (preferred option) Know Before You Go®: You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the Simple Term 20, Simple Term 30, Simple Term 20 ROP, or Simple Term 20 DLX plan and hand the phone to your client **(Be specific as to which product you want so that only the plan-specific questions will be asked).** During the call, the interviewer will conduct MIB and Prescription Drug searches to better determine your client's suitability for the product you've selected. Upon completion of the interview, and based on the client's answers to the questions and results of the database searches, the interviewer will tell you whether or not the application should be sent to the Home Office.

Did you complete a point-of-sale Personal History Interview with your client? ☐ Yes ☐ No

Option 2: UHL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all Simple Term 20, Simple Term 30, Simple Term 20 ROP, and Simple Term 20 DLX sales, regardless of face amount. What is the best time to reach this client?

Home Phone (_____) _____ available days? ☐ Yes ☐ No

Business Phone (_____) _____ available days? ☐ Yes ☐ No

Cell Phone (_____) _____ available days? ☐ Yes ☐ No

If a language other than English is required, please specify _____.

Important Reminders

1. **UHL TERM PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING THE AGE OF THE PROPOSED INSURED FOR INSURANCE PURPOSES.**
2. Print legibly in English.
3. Keep original app until policy is issued.
4. If faxing, keep fax confirmation message that fax was successful.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash is not permitted for the payment of premium(s).
7. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be provided to the Proposed Insured. These documents must also be provided to any applicant who completes the Know Before You Go® (point-of-sale) PHI process, regardless of whether an application is written or not. If applicable, the Notice of Insurance Information Practices must also be provided to the Owner.
8. If requesting an agent commission split because of multiple writing agents, please indicate each agent's name, agent code, and the commission split percentage in the Special Instructions section. At least one writing agent is required to sign the application.
9. **Appointment regulations vary by state. A few states require appointment before an application can be taken; several others require appointment within a period of days after an application is written. Contact the Home Office or check with your state to ensure compliance prior to taking an application.**

Term Life Insurance Application

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

SECTION 1 – Proposed Insured

Last Name	First Name	Middle Initial

Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight

Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*

Street Address (Physical street address, not a P.O. Box)

City	State	Zip Code

Phone Number ( )	Email Address

Billing Address (Owner's P.O. Box if applicable)	City	State	Zip Code

Secondary Addressee/ Third Party (For Past Due Notices)	Name	Street Address

City	State	Zip Code

Employer/Occupation/Duties/How Long There (Required)

SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name	Relationship	Social Security Number

Owner Street Address (Physical street address, not a P.O. Box)	City

State	Zip Code	Owner Email Address

Contingent Owner Name	Relationship	Social Security Number

SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name			Relationship
Age	**Date of Birth (M-D-Y)**	**Social Security Number**	**Share %**
Primary Beneficiary Name			**Relationship**
Age	**Date of Birth (M-D-Y)**	**Social Security Number**	**Share %**
Contingent Beneficiary Name			**Relationship**
Age	**Date of Birth (M-D-Y)**	**Social Security Number**	**Share %**

SECTION 4 – Plan of Insurance

Plan of Insurance ❑ Simple Term 20 ❑ Simple Term 30 ❑ Simple Term 20 ROP ❑ Simple Term 20 DLX

❑ Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a face amount less than any indicated on this application and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

Face Amount: $_____

❑ Accidental Death Benefit (not available with Simple Term 20 ROP) $ _____

❑ Waiver of Premium (not available with Simple Term 20 ROP or Simple Term 20 DLX)

SECTION 5 – Payment Information

Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly EFT* Modal Premium Amount $_____

$_____ paid with application.

*If selected, complete EFT authorization form.

SECTION 6 – Other Insurance

Will this insurance replace or change any other insurance policies or annuities? ❑ Yes ❑ No

If "Yes," please complete any necessary replacement forms.

SECTION 7 – Stranger Owned Life Insurance

Is there, or will there be, any agreement or understanding that provides for a party, other than the Owner, to obtain any interest in any policy issued on the life of the Proposed Insured as a result of this application? ❑ Yes ❑ No

SECTION 8 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months? ❑ Yes ❑ No

SECTION 9 – Physician Information

Name of Family Physician (Required)	Family Physician Phone Number (Required) ( ) -

Family Physician Address (Required)

SECTION 10 – Medical Questions

PART A – SIMPLE TERM 20 DLX – COMPLETE PART A ONLY

If any question in Part A is answered "Yes", the Proposed Insured is not eligible for any plan of insurance.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been diagnosed by a licensed member of the medical profession as needing an organ transplant or have you been diagnosed by a licensed member of the medical profession as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twelve (12) months.)	❑ Yes ❑ No
B. Do you require assistance to feed, bathe, dress, or take your own medication or are you currently confined to a hospital, nursing home, medical related facility, or require home health nursing care?	❑ Yes ❑ No
C. Has the Proposed Insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❑ Yes ❑ No
D. In the past twelve (12) months:	
1. Other than for temporary or minor conditions, have you been confined to a hospital two or more times?	❑ Yes ❑ No
2. Have you used any illegal drugs?	❑ Yes ❑ No
E. In the past 5 years:	
1. Have you been diagnosed or treated by a licensed member of the medical profession for, or are you currently under treatment by a licensed member of the medical profession for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance, or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension (controlled hypertension means blood pressure, regardless of treatment, has not exceeded 170/100)) or Stroke?	❑ Yes ❑ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis, nephropathy) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (including neuropathy, excluding controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ No
2. Have you been advised by a licensed member of the medical profession to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	❑ Yes ❑ No
3. Have you been treated by a licensed member of the medical profession for or been advised to have treatment by a licensed member of the medical profession for alcohol or drug dependency or consumed more than 10 alcoholic drinks per day?	❑ Yes ❑ No
F. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No

PART B – ALL OTHER TERM PLANS – COMPLETE PARTS A & B

If any question in Part B is answered "Yes", the Proposed Insured is not eligible for any term plans in Part B. Submit the case as Simple Term 20 DLX.

A. In the past 2 years have you been declined or postponed for Life Insurance?	❑ Yes ❑ No
B. In the past 5 years:	
1. Have you been diagnosed or treated by a licensed member of the medical profession for, or are you currently under treatment by a licensed member of the medical profession for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No

b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
C. Are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	❑ Yes ❑ No
D. Do you now participate in, or do you have plans within the next 2 years to participate in scuba diving, sky diving, hang-gliding, mountain climbing, rock climbing, any form of motorized racing, or any type of flying as a pilot or crew member?	❑ Yes ❑ No

SECTION 11 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate whether written by my own hand or not. I understand and agree that no information or knowledge obtained by any agent, medical examiner, or any other person in connection with this application shall be construed as having been made known to or binding upon United Home Life Insurance Company unless such information is in writing and made a part of this application. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

WARNING

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I hereby certify under penalties of perjury, that the tax identification number provided is true, correct, and complete.

SECTION 12 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, or other medical or medically related facility, electronic health record provider, medical information retrieval service, insurance company, MIB, Inc. ("MIB"), or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, MIB, persons or entities performing business, professional, or insurance functions for UHL or as may otherwise be legally allowed. I further authorize UHL or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. UHL may not disclose HIV, AIDS, or AIDS-related information outside of the insurance company or its employees, insurance affiliates, agents, or reinsurers, except to me and the persons I have designated in writing.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen. The HIV screen will be one recommended by the Centers for Disease Control and Prevention or by the federal Food and Drug Administration. Prior to testing I must be provided and sign a separate Notice and Consent for Blood Fluid and Other Bodily Fluid Testing which may include AIDS Virus Antibody Testing form.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

SECTION 13 – HIPAA Authorization

This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of sexually transmitted diseases. United Home Life Insurance Company may not disclose HIV, AIDS, or AIDS-related information outside of the insurance company or its employees, insurance affiliates, agents, or reinsurers, except to me and the persons I have designated in writing. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have a right to receive a copy of this authorization.

SECTION 14 – Disclosure Acknowledgement

☐ I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount.

SECTION 15 – Signatures

Signature applies to Sections 1 through 14. Review before signing.

Dated at _____ (City) , this _____ day of _____ (Month) , _____ (Year)

_____
Signature of Proposed Insured or personal representative

_____
Description of personal representative's authority to act

_____
Signature of Owner (If other than Proposed Insured)

SECTION 16 – Agent's Certification and Signature

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

☐ I certify that I have provided the Owner a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail_____

Agent: Phone # _____ Fax#_____ License Identification Number (_____) _____
State

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application,
please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank. Do not pay with cash.

I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Unless authorized by you such report will not include any HIV, AIDS, or AIDS-related information. If you 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you 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, Massachusetts 02184-8734, telephone number 866-692-6901.

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted, with the exception of HIV, AIDS, or AIDS-related information. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$100,000.00
Less 7%	6,542.06
Accelerated Benefit	**$ 93,457.94**

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION FORM

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192
Phone: 1-800-428-3001
Fax: New Policy Application: 317-692-7711
Fax: Existing In Force Policy: 317-692-8402

Section 1 – Financial Institution Information - Always Complete This Section		
Financial Institution Name		
Financial Institution Address		
Account Number	Routing Number	Type of Account (check one) ☐ Checking ☐ Savings
Account Holder Printed Name		Relationship if other than Owner

Section 2 – Complete This Section For A New Policy Application

Name of Proposed Insured

The initial modal premium must be quoted in the payment information section of the application. We do not accept debit or credit cards at the time of application. **I understand that the policy will not be effective until the later of: the date it is issued by the Company as applied for and the premium paid; or the date of the Owner's written acceptance of the policy if issued other than applied for and the premium paid.**

1. Draft my account for the **first** premium (check one):

   ☐ Immediately upon receipt of the application in the Home Office.
   ☐ On the date of issue (policy date).
   ☐ On _____ (month & day). Choose any day between the 1st and the 28th.
   ☐ On the [☐ 2nd ☐ 3rd ☐ 4th] (check one) Wednesday of _____(month).
   ☐ Do NOT draft my account for the first premium. The first premium is attached, is being mailed, or will be collected on delivery. The Company name should appear as the Payee. Do not leave the Payee field blank, do not make payable to the agent, and do not postdate. Do not pay with cash.

2. Unless indicated below all **subsequent** premiums will be drafted on the same day each month as the **first** premium.

   Draft subsequent premiums on the _____ (1st – 28th) day of each month.

Section 3 – Complete This Section For An Existing In Force Policy

Name of Insured	Policy Number

Requested draft day _____ (1st – 28th) **OR** the [☐ 2nd ☐ 3rd ☐ 4th] (check one) Wednesday of each month. If day is not specified, the draft day will be based upon the date of issue (policy date).

Section 4 – Authorization – Always Complete This Section

I request and authorize my financial institution to honor deductions from my account that are initiated by United Home Life Insurance Company or United Farm Family Life Insurance Company (the "Company") for the current policy premium, including policy renewals and/or changes. By signing below, I authorize the Company to receive information from the financial institution named so my account number and routing number may be verified.

I understand and agree that the Company is not responsible for any charges from my financial institution and that a dishonored deduction will not be resubmitted and may cause the policy to lapse for non-payment of premium. I may terminate this EFT Authorization by giving 15 days prior written notice to the Company. The Company may terminate this EFT Authorization agreement upon any deduction returned as dishonored, or upon 15 days prior written notice.

Account Holder Signature _____ Date _____

HOME OFFICE USE ONLY

Call Representative/ACID _____ Date _____ Time _____ Call ID# _____

UNITED HOME LIFE INSURANCE COMPANY
P.O. Box 7192
Indianapolis, IN 46207-7192
Phone: (317) 692-7979 Fax: (317) 692-7711

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both sides before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summaries your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by **placing your initials** in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may replaced:

Company Name	*Policy Number*	*Name Of Insured*

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☐ Yes ☐ No

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I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may replaced:

Company Name	*Policy Number*	*Name Of Insured*

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☐ Yes ☐ No

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I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may replaced:

Company Name	*Policy Number*	*Name Of Insured*