



Agent Number: _____

P.O. Box 14410 Des Moines, IA 50306-3410

Fax: 515-247-2500 • Phone: 1-800-733-5454

Email: FENEW@GWIC.COM • Website: www.gwic.com

Application for Individual Life Insurance

A. Proposed Insured (Full legal name)

First Name		Middle Initial	Last Name	
Street Address		City	State	Zip Code
Phone Number		Date of Birth (mm / dd / yyyy)		Social Security Number
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address			

B. Owner (Complete only if other than proposed Insured)

First Name		Middle Initial	Last Name	
Street Address		City	State	Zip Code
Phone Number		Date of Birth (mm / dd / yyyy)		Social Security Number
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address		Relationship to Insured	

C. Health Questions

- 1) In the last two years, has the applicant been a patient in hospice, a hospital, or a nursing home for five or more days? Yes No
- 2) Is the applicant unable to independently perform routine activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? Yes No
- 3) In the last two years, has the applicant been diagnosed with, been prescribed medication for or treated by a healthcare provider for any of the following diseases: Cancer (other than basal cell carcinoma), Tumor, Insulin-Dependent Diabetes, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Acquired Immune Deficiency Syndrome-Related Complex (ARC), or any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System, or Liver? Yes No
For Prescriptions: Please do not mark "Yes" if the prescription(s) is a maintenance medication and has remained the same (or the generic equivalent) at the same or at a decreased dosage for the past two years. For Treatment: Please do not mark "Yes" if your visit(s) with your healthcare provider in the last two years was a routine review of your maintenance medication and no additional treatment was given or diagnosis was made during your visit(s).

If all of the health questions are answered "NO," then the proposed Insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES" or are not answered, then the Policy will be issued with a Graded Death Benefit.

Primary Care Physician <i>(Required for Level Death Benefit)</i>	Phone Number
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D. Policy Information

Face Amount: \$	Ultimate Death Benefit: \$ <i>For Level Death Benefit, multiply Face Amount by 125%</i>
Payment Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually	Base Premium Amount: \$
<input type="checkbox"/> Dependent Child / Grandchild Rider <i>(complete separate application)</i> \$5,000 Face Amount on base Policy is required	Rider Premium Amount: \$
Total Premium Amount: \$	

Spousal Bonus Rider – Full Name and Date of Birth:
\$10,000 Face Amount on each Policy is required

E. Beneficiary Information (Use additional form for more beneficiaries)

Primary (Full legal name)		Relationship	
Street Address	City	State	Zip Code
Contingent (Full legal name)		Relationship	
Street Address	City	State	Zip Code

F. Agreement

By signing below, I agree: (1) To the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Insured must be alive and in the same health as described or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the Policy is delivered. By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that have been made to the Policy for which I am applying.

Insurable Interest: I certify compliance with all of the insurable interest laws in force in the state in which this Policy will be issued.

Authorization: I authorize any healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the Insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to the Insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for twenty-four (24) months from the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC.

I affirm that no illustration was used in the sale of this product.

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offence and subject to penalties under state law.

G. Privacy Policy

I agree to receive electronically all initial and annual privacy policy notices associated with this insurance policy. Notices will be sent to the email address provided above. Yes No _____
Initial

H. Signature Section

Do you have any existing insurance policies or annuity contracts? Yes No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? Yes No
If "Yes, complete required replacement form(s).

X _____ Signed on: _____ Signed at: _____
Proposed Insured's Signature (mm / dd / yyyy) (City, State)

X _____ Signed on: _____ Signed at: _____
Owner's Signature (If other than Proposed Insured) (mm / dd / yyyy) (City, State)

I. Agent Section

Does the applicant have any existing insurance policies or annuity contracts? Yes No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? Yes No

_____ Agent Full Name (Please print)

_____ Agent Number

X _____ Signed on (mm / dd / yyyy)
Agent's Signature



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Child/Grandchild Protection Plan

State _____ (Print) Agent Name _____ Agent Number _____ Date _____

Insured's Information			
First Name	Middle Initial	Last Name	
Street Address	City	ST	Zip
Phone #	Date of Birth (mm/dd/yyyy)	Social Security #	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email Address		

Child / Grandchild Protection Rider Information	
Existing Policy #	Rider Premium \$1.00 per month
Does the applicant have any existing policy or annuity? <input type="checkbox"/> YES <input type="checkbox"/> NO Will the proposed insurance replace any existing policy or annuity? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please complete a replacement form</i>	

Conditions of Child / Grandchild Protection Plan
<p>I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.</p> <ul style="list-style-type: none"> • The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married. • The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years. • The Covered Child / Grandchild dies while the Insured on the base Policy is alive. • The coverage under the base Policy to which this Rider is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Agreement	
<p>Agree by signing below, I agree that (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that GWIC may make to the Policy for which I am applying.</p>	
X _____ Insured's Signature	Signed on _____ (mm/dd/yyyy) Signed at _____ (City, State)
X _____ Owner's Signature (If other than the Proposed Insured)	X _____ Agent's Signature
For the Agent: Is replacement of insurance involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.</p>	

Life Replacement Advertising

AGENT'S STATEMENT

I, _____ have complied with the following in connection with the replacement sales transaction:

- a. I have used only company approved sales advertising.
- b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X

Agent Signature

Agent Number

Date

Life Replacement Advertising

AGENT'S STATEMENT

I, _____ have complied with the following in connection with the replacement sales transaction:

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Notice Regarding Replacement

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there maybe surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

- 1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Yes No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Table with 4 columns: INSURER NAME, CONTRACT OR POLICY #, INSURED OR ANNUITANT, REPLACED (R) OR FINANCING (F). Rows 1, 2, 3.

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

I certify that the response herein are, to the best of my knowledge, accurate:

X
Applicant's Signature Applicant's Printed Name Date
X
Agent's Signature Agents's Printed Name Date

BE SURE TO READ THESE IMPORTANT POINTS TO CONSIDER

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

Policy Values:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisitions costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

Insurability:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

If You Are Keeping The Old Policy As Well As The New Policy:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

If You Are Surrendering An Annuity Or Interest Sensitive Life Product:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

Other Issues To Consider For All Transactions:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?



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- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grand-fathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?



Information on the Accelerated Death Benefit Rider

INCLUSION OF RIDER

If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER

Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION

Qualifying Medical Condition means either: 1.) Terminal Illness - You are terminally ill. You are expected to die within 12 months. Or 2.) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days. Or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS

The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT

The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE

This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS

This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION

When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X
Applicant's Signature
X
Agent's Signature
Date

BANK DRAFT INFORMATION

Complete this section only if you selected the automatic bank withdrawal payment option.

Ongoing Premium

Authorization to Bank or Other Financial Institution

Checking Savings Requested Withdrawal Date (1st - 28th only) _____

First Name (as it appears on account)

M.I.

Last Name (as it appears on account)

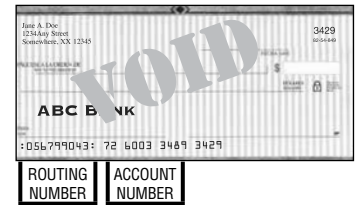
Bank or Financial Institution Name (including branch, if any)

Routing Number

Bank or Financial Institution's Address

Account Number

Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Great Western Insurance Company (the "Company") for insurance premiums. I authorize the Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.



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Receipt for Initial Premium

Final Expense Receipt

I, the listed agent below, have received an application from _____
(Applicant's Name)

for a Final Expense Whole Life Insurance policy with the following rider:

Dependent Child / Grandchild Rider

Face amount of Life Insurance applied for: \$ _____.

Amount of initial premium received by agent: \$ _____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If you do not hear from our company within 30 days, please contact us by one of the following methods:

Write to:

Great Western Insurance Company
PO Box 14410 • Des Moines, IA 50306-3410

Call:

Customer Care at 1-800-733-5454

Agent's Signature

Date

Agent's Printed Name