GWIC® GREAT WESTERN INSURANCE COMPANY

Application for Individual Life Insurance

❒ New coverage ❒ Reinstatement of policy # _____

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

Part A: Proposed Insured *(Full legal name)*

Full name of applicant - *first name, M.I., last, suffix* | Date of birth *(MM/DD/YYYY)* | Gender

Address | City | State | ZIP code

Phone number | Email address | Social Security number

Part B: Owner *(Complete only if other than proposed insured)*

Full name of owner - *first name, M.I., last, suffix* | Date of birth *(MM/DD/YYYY)* | Gender

Address | City | State | ZIP code

Phone number | Email address | Relationship to insured | Social Security number

Part C: Policy Information

If all of the questions in Part D can be answered "NO," then the proposed insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES," are not answered, or it is determined during the underwriting process they should have been answered "YES," then the policy will be issued with a Graded Death Benefit.

❒ Level Death Benefit ❒ Graded Death Benefit Requested effective date: _____

Face amount: $_____ Ultimate Death Benefit: $_____

For Level Death Benefit, multiply face amount by 125% to determine the Ultimate Death Benefit.

Payment mode: ❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually Base premium amount: $_____

❒ Dependent child/Grandchild rider *(complete separate application)*
$5,000 face amount on base policy is required Rider premium amount: $_____

Total premium amount: $_____

Part D: Medical Information *(Do not complete if applying for Guaranteed Assurance - Graded Death Benefit)*

1. In the last 24 months have you been confined to a bed, received hospice care, been in a hospital or a nursing home for 5 or more days in total? ❒ Yes ❒ No

2. Do you require assistance or supervision to perform routine daily activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? ❒ Yes ❒ No

3. In the past 24 months have you consulted a member of the medical profession, been treated for, been diagnosed with or taken medication for any of the following:
   - diabetes requiring insulin, with complications, or requiring 3 or more medications;
   - internal cancer, malignant melanoma, leukemia, Hodgkin's Disease, or lymphoma;
   - heart surgery including bypass, angioplasty or stent placement, congestive heart failure, heart attack, stroke, peripheral vascular disease, or aneurysm;
   - emphysema, chronic obstructive pulmonary disease (COPD), or oxygen use;
   - a neuromuscular disease, Amyotrophic Lateral Sclerosis (ALS), Parkinson's, or Multiple Sclerosis;
   - kidney failure or dialysis;
   - liver disease such as chronic hepatitis or cirrhosis;
   - dementia, Alzheimer's disease, or schizophrenia;
   - alcohol or drug abuse; or
   - organ transplant?

   ❒ Yes ❒ No

4. a. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ❒ Yes ❒ No
   b. In the last 24 months have you received treatment from a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?
   ❒ Yes ❒ No

Part D: Medical Information - continued

Please provide the name and phone number of your Primary Care Physician (required for Level Death Benefit):

Primary Care Physician's name | Phone number

Part E: Beneficiary

Primary (*full legal name)* | Relationship to insured | Phone number

Address | City | State | ZIP code

Contingent (*full legal name)* | Relationship to insured | Phone number

Address | City | State | ZIP code

Part F: Application Agreement

By signing below, I agree: (1) I represent 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 above or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the policy is delivered. (4) 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.

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 offense and subject to penalties under state law.

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? *If "Yes," complete required replacement form(s).* ❒ Yes ❒ No

X

Proposed insured's signature | Date *(MM/DD/YYYY)*

X

Owner's signature *(If other than proposed insured)* | Date *(MM/DD/YYYY)*

Part G: Agent Certification

I certify that the answers from the proposed insured to Part D were recorded accurately.

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

X

Agent full name *(please print)* | Agent number

X

Agent's signature | Date *(MM/DD/YYYY)*