GCU Eternal Advantage

Application for Individual Whole Life Insurance

5400 Tuscarawas Road, Beaver, PA 15009-9513
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Part 1

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. Producer Acknowledges ☐ Client Acknowledges ☐

1. Proposed Insured – *Note: If residing at present address for less than 12 months, complete Prior Address Form.*

First Name	Middle Name	Last Name	Gender M ☐ F ☐	Date of Birth(mm/dd/yyyy)	SSN/Tax ID

Residence Street Address/Apt #	City	State	ZIP Code	State of Birth

Email Address	Cell ☐ Preferred Phone Work ☐ Home ☐	Driver's License/ID #	State or Country	Exp. Date (mm/dd/yyyy)

Annual Income	Occupation

U.S. Citizen Yes ☐ No ☐ *If "No," please complete the questions below.*

Permanent Resident Card Holder	If "Yes," Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.
Yes ☐ No ☐	If "No," do not proceed.					

2. Screening Questions

IF ANY OF THE FOLLOWING ARE ANSWERED "YES" THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED

1. Are you currently hospitalized, confined to a correctional facility or do you need the help of another person in performing any of the activities of daily living: toileting, dressing, eating, walking or bathing?	Yes ☐ No ☐
2. In the past 12 months, have you been hospitalized, admitted to a nursing facility, assisted living facility, received hospice care, or used oxygen to assist in breathing?	Yes ☐ No ☐
3. Have you ever been diagnosed or told by a licensed member of the medical profession that you have a terminal illness (life expectancy of 12 months or less)?	Yes ☐ No ☐
4. Have you ever been diagnosed, tested positive, treated, been prescribed or taken medications, or given medical advice by a licensed member of the medical profession for:	
a. Human Immunodeficiency Virus (AIDS virus), any immune deficiency related disorder, or tested positive for Acquired Immune Deficiency Syndrome (AIDS)?	Yes ☐ No ☐
b. Alzheimer's, dementia, memory loss, muscular dystrophy, Huntington's disease, or Lou Gehrig's disease (ALS) cystic fibrosis, sickle cell anemia?	Yes ☐ No ☐
c. Dialysis, renal (kidney) failure, congestive heart failure (CHF), liver failure/cirrhosis, or respiratory failure or amputation due to disease?	Yes ☐ No ☐
d. Organ or bone marrow transplant (other than corneal), Diabetic Coma, Insulin shock, eye or renal (kidney) problems due to complications from diabetes?	Yes ☐ No ☐
5. Have you ever been diagnosed by a licensed member of the medical profession with more than one occurrence of the same or different type of cancer, or do you currently have cancer (excluding basal cell skin cancer, or carcinoma situ)?	Yes ☐ No ☐
6. In the past 5 years, have you been advised by a licensed member of the medical profession to have surgery or a diagnostic test (excluding regular preventative screenings) which has not yet been started, completed, or for which results are not known?	Yes ☐ No ☐

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Part 2

3. Physical Screening Questions

1. Name of Personal Care Physician / Health Care Provider:		2. Date of Last Physical: (mm/yyyy)	
3. Physician Street Address	City	State	ZIP Code
4. What is your current height and weight? Height: ft. in. Weight lbs.	In the past 12 months, have you used tobacco, including cigarettes, e-cigarettes (electronic cigarettes), vaping or nicotine substitute products (excluding cigar or pipe use less than 12 times per year? Yes ☐ No ☐		

4. Modified Screening Questions

7. Have you been diagnosed, tested positive, treated, been prescribed or taken medications, or given medical advice by a licensed member of the medical profession for:	
a. Leukemia ☐ Lymphoma ☐ Multiple Myeloma ☐	Yes ☐ No ☐
b. Pulmonary Fibrosis ☐ Hemophilia Systemic lupus-erythematosus (SLE) ☐ Chronic Renal (kidney) Insufficiency ☐	Yes ☐ No ☐
c. Schizophrenia ☐ Down Syndrome ☐	Yes ☐ No ☐
8. In the past 5 years, have you been diagnosed, tested positive, treated, been prescribed or taken medications, or been given medical advice by a licensed member of the medical profession for:	
a. Any form of cancer (not including basal cell or squamous cell skin cancer) ☐ or metastasis (spreading) of cancer ☐	Yes ☐ No ☐
9. In the past 2 years, have you been diagnosed, tested positive, treated, been prescribed or taken medications, or been given medical advice by a licensed member of the medical profession for:	
a. Aneurysm ☐ heart attack/myocardial infarction ☐ coronary artery disease ☐ cardiomyopathy ☐ heart disease ☐ pulmonary hypertension ☐ stroke/TIA ☐ surgery of the heart (angioplasty, bypass, heart valve replacement, stent, pacemaker or defibrillator) ☐ or any other heart or circulatory disease ☐	Yes ☐ No ☐
10. In the past 3 years have you used narcotics, barbiturates or any other illegal drug except as prescribed by a licensed doctor or medical practitioner ☐ or been advised by a licensed doctor or medical practitioner to be treated for alcohol or drug misuse ☐	Yes ☐ No ☐

* ***If all questions in Part 4 are answered "No," please proceed to Part 5.***
* ***If one question in Part 4 is answered "Yes," the proposed Insured is potentially eligible for the Modified Death Benefit product, please proceed to Part 9.***
* ***If two or more questions in Part 4 are answered "Yes," the proposed Insured is not eligible for any coverage, please proceed to Part 17 for signatures.***

5. Preferred/Standard Screening Questions

11. Have you ever been diagnosed, tested positive for, treated, prescribed/taken medications, or been given medical advice by a licensed member of the medical profession for:	
a. Parkinson's disease ☐ Paralysis ☐ multiple sclerosis ☐ or scleroderma ☐	Yes ☐ No ☐
b. Chronic obstructive pulmonary disease (COPD) ☐ emphysema ☐ or any other chronic lung/respiratory disease ☐	Yes ☐ No ☐
c. Chronic pancreatitis ☐ Hepatitis B ☐ and or C ☐ or any other disorder of the liver ☐	Yes ☐ No ☐
d. Bipolar disorder ☐or been hospitalized ☐ or had a suicide attempt ☐ in the past 2 years for any mental or nervous disorder?	Yes ☐ No ☐
12. In the past 3 years, have you been diagnosed, tested positive, treated, been prescribed or taken medications, or been given medical advice by a licensed member of the medical profession for:	
a. Aneurysm ☐ heart attack/myocardial infarction ☐ coronary artery disease ☐ cardiomyopathy ☐ heart disease ☐ stroke/TIA ☐ surgery of the heart (angioplasty, bypass, heart valve replacement, stent, pacemaker or defibrillator) ☐ peripheral vascular disease ☐ or peripheral artery disease ☐	Yes ☐ No ☐

5. Preferred/Standard Screening Questions *(continued)*

b. Carotid artery disease requiring surgery ☐ irregular heart rhythm such as atrial fibrillation ☐ or any other heart surgery or circulatory disease ☐	Yes ☐ No ☐
c. Diabetes with insulin use?	

* ***If all questions in Part 5 are answered "No," the proposed Insured is potentially eligible for the Preferred product, please proceed to Part 7.***
* ***If one question in Part 5 is answered "Yes," the proposed Insured is potentially eligible for the Standard product, please proceed to Part 6.***
* ***If two or more questions in Part 5 are answered "Yes," the proposed Insured is potentially eligible for the Modified Death Benefit product, please proceed to Part 6.***

6. Provide details to all "Yes" answers in Section 5.

Question #	Medical Condition(s) and Medications	Date Diagnosed

7. Nursing Home Waiver of Premium *(Preferred Issue Only)*

Yes ☐ No ☐

8. Grandchild Rider Information *(Preferred & Standard Issue Only)*

Yes ☐ No ☐

Grandchild Rider $_____ *Add Grandchild information to the Supplemental Grandchild Rider Form attached)*

(Rider Face Amount is the lesser of 40% of original death benefit or $20,000) Rider Face Amount will be the same for all grandchildren

9. Product Selection - Face Amount - Frequency

☐ Preferred - Non-Tobacco
☐ Preferred - Tobacco
☐ Standard - Non-Tobacco
☐ Standard - Tobacco
☐ Modified - Non-Tobacco
☐ Modified - Tobacco

Face Amount $_____

Base Premium $_____

Nursing Home Premium Waiver (Preferred Only) $_____

Grandchild Rider Premium (Preferred & Standard Only) $_____

Total Premium $_____

Billing Frequency

☐ Annual ☐ Semi-Annual
☐ Quarterly ☐ Monthly

General Guidelines

Preferred Level - $5,000 - $35,000
Standard Level - $5,000 - $25,000
Modified Level - $5,000 - $15,000

10. Ownership (Complete ONLY if other than the Proposed Insured)

Note: If the owner is a trust, please attach or mail a copy of the Trust along with the application.

First Name	Middle Name	Last Name	SSN/Tax ID	Date of Birth (mm/dd/yyyy)

Residence Street Address/Apt #	City	State	ZIP Code	Preferred Phone
				Cell ☐ Work ☐ Home ☐

Relationship to Proposed Insured	Email Address	Annual Income

Trust Name (if applicable)	Occupation

U.S. Citizen Yes ☐ No ☐ ***If "No," please complete the questions below.***

Permanent Resident Card Holder	If "Yes," Permanent Resident/Green Card No.	Issue Date	Expiration Date	Country of Birth	Country of Citizenship	Years in U. S.
Yes ☐ No☐	If "No," do not proceed.					

11. Policy Beneficiary Designation Note: *If there are additional Beneficiaries to be named, or if the beneficiary is a trust, please include an additional sheet with the appropriate information. Only the owner has the right to change beneficiaries.*

1. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		
2. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		
3. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		
4. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		
5. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		
6. ☐ **Primary** ☐**Contingent**	First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	% Share
Relationship to Proposed Insured		Country of Residence (if outside U.S.)	SSN/Tax ID		

12. Premium Payor Information (Complete ONLY if premium is paid by someone other than Owner)

First Name	Middle Name	Last Name	SSN/Tax ID		
Residence Street Address/Apt #		City	State	ZIP Code	Cell ☐ Work ☐ Home ☐ Preferred Phone
Relationship to Proposed Insured/Owner		Annual Income	Occupation		

The USA PATRIOT Act requires insurance companies to obtain all relevant customer-related information necessary to establish an effective anti-money laundering program. In accordance with the USA PATRIOT ACT and the Company's anti-money laundering program, the Company will ask individuals for identifying information including their name, address, date of birth, and a driver's license or other government issued identification that will allow us to verify their identity. For certain entities, such as trusts, estates, corporations, partnerships, or other organizations, identifying documentation is also required. For both individuals and legal entities, the Company may include the use of third-party sources to verify the information provided.

13. Secondary Addressee (Complete ONLY if designating another person to receive notification of possible lapse in coverage)

First Name	Middle Name	Last Name	Relationship to Owner

Residence Street Address/Apt #	City	State	ZIP Code

14. Bank Draft Authorization

Please attach a voided check OR provide the banking information below for Electronic Funds Transfer.

Account Information:

Routing Number: _____ 9 positions in Routing Number

Account Number: _____ Can have up to 17 positions in Account Number

Name of Financial Institution: _____

Please select one of the following. If selecting a draft date, select any date between the 1st and the 28th of the month (Monthly-M, Quarterly-Q, Semi-Annual-S, Annual-A)

☐ Draft my initial premium on the issue date of my policy and draft subsequent premiums _____ (Mode-(M-Q-S-A)) thereafter.

☐ Draft my initial premium on the issue date of my policy and draft subsequent premiums on _____ (Date (1-28)) and _____ (Mode-(M-Q-S-A)) thereafter.

☐ Hold issue of my policy until _____ (mm/dd/yyyy) and draft my initial premium on that date. Draft subsequent premiums _____ (Mode-(M-Q-S-A)) thereafter.

Authorization Agreement for Preauthorized Payments

I, the bank account owner, authorize the Company to initiate Electronic Funds Transfers (EFT) from the above-named bank and bank account in an amount not to exceed my scheduled premium. I understand that I must contact you at least three business days before a scheduled withdrawal to change or cancel this authorization. I understand that the Company will only consider a premium paid if the EFT is honored by my bank. I further understand that if the account has insufficient funds to pay the initial required premium, or if the EFT cannot be successfully made for any other reason, the policy will not take effect. Once a policy is in effect, unsuccessful EFT payments may result in termination of the policy. I understand that any bank fees are my responsibility.

Bank Account Owner – First Name	Middle Name	Last Name

Bank Account Owner Signature	Date (mm/dd/yyyy)

15. Insurance History

1. Does the Proposed Insured have any pending life insurance applications?	Yes ☐ No ☐
2. Does the Proposed Insured currently have any life insurance in force?	Yes ☐ No ☐
3. Is the insurance applied or intended to replace any insurance policy or annuity now in force?	Yes ☐ No ☐

16. Authorization to Obtain Information

"Affiliates" means reinsurers, insurance producers and agencies and those performing services in relation to an application for insurance, insurance product or benefit claim. For purposes of assessing insurance coverage eligibility, coverage continuation and/or benefit claim, I, the Proposed Insured, authorize the Company and its affiliates to obtain information, including previously restricted information, about me from any: physician, medical practitioner, hospital, clinic, or medical facility; employer; benefit plan; other insurer or institution; consumer reporting agency; public records; pharmacy, pharmacy benefits manager, or other pharmacy related services organization; or MIB, Inc. This includes records or other information as to past, current, or future: diagnosis, treatment and prognosis of a physical or mental condition; drug, physical and mental health, and alcohol-related information that may be protected by federal or state laws and regulations. I, the Proposed Insured, authorize the Company and its affiliates to make a brief report of my personal and/or protected health information to MIB, Inc. Information may be disclosed: between and among the Company and its affiliates; companies that I have applied or may apply to for life or health insurance, or benefits; as required or permitted by law. Obtained or disclosed information may no longer be protected by federal privacy laws. This authorization's 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. A copy of this authorization shall be as valid as the original. This authorization may be revoked at any time by written notice to the Company, except that action(s) taken before receipt of notice will not be affected. A copy of this authorization will be provided upon request. I have received the Privacy Statement.

17. Signature

As the Proposed Insured and / or the Owner, if other than the Proposed Insured, ("I"), understand that the Application for life insurance consists of two parts, a Part 1 and Part 2. I have reviewed this application, and the statements made herein are those of the proposed insured and all such statements made by the proposed insured in Part 1 and Part 2 of this application are full, complete, and true to the best knowledge and belief of the undersigned and have been correctly recorded. I understand that the Company will rely upon the information provided in the Application and that the statements and answers made therein are the basis for any policy issued by the Company, and that no information about them will be considered to have been given to the Company unless it is stated in the application. Before issuing an insurance policy, the Company may require and obtain information about me to validate my identity.

I understand that 1) no statements made to or information acquired by any licensed Producer who takes this Application shall bind the Company, and 2) no licensed Producer has authority to make, modify, alter or discharge any contract hereby applied for, and 3) if there is any change in health or personal history that would alter the answers to any of the questions in the Application between now and when the policy is delivered, I will inform the Company in writing as soon as possible at 5400 Tuscarawas Road, Beaver, PA 15009-9513.]

I understand and agree that the insurance applied for shall not take effect unless each of the following has occurred: 1) the policy has been issued by the Company; 2) the premium required for issuance of the policy has been paid in full; 3) the Proposed Insured is alive when the premium is paid and when the policy is delivered; 4) all representations made in the Application remain full, complete and true as of the date the policy is delivered; 5) a policy is issued on this application and delivered to and accepted by the owner; and 6) any required forms or amendments to the Application are signed and returned to the Company.

Proposed Insured's Signature	State Signed In	Date (mm/dd/yyyy)
Owner's Signature (Only if Owner is other than the Proposed Insured)	State Signed In	Date (mm/dd/yyyy)

18. Producer Certification

1. Will this policy replace any existing insurance or utilize values from any existing life insurance policy or annuity (through loans, surrenders or otherwise) to pay the initial premium for this policy? (If "Yes," complete Replacement Form)	Yes □ No □
2. Are there any life insurance policies or annuity contracts owned by, or on the life of, the applicant, or the Proposed Insured, or the owner, or the annuitant? (If "Yes," complete Replacement Form)	Yes □ No □
3. If applicable, was the customer given the state required replacement disclosures?	Yes □ No □
4. Was a copy of the Buyer's Guide provided to the owner at the time of sale?	Yes □ No □
5. Are you related to the Proposed Insured/Owners? If "Yes", how are you related?	Yes □ No □
6. Select a policy delivery method: □ Deliver to the Owner □ Deliver to Producer	

Please certify one of the following:

□ I certify that I personally met with the Proposed Insured and reviewed their valid, government-issued ID. To the best of my knowledge, the ID accurately reflects the identity of the Proposed Insured.

□ I did not personally meet with the Proposed Insured, however, I certify that I have reviewed their valid government-issued ID. To the best of my knowledge, the ID accurately reflects the identity of the Proposed Insured.

I certify that the information provided by the Proposed Insured is accurately recorded on the application and I am not aware of any discrepancies or misrepresentation in the recorded information. I am qualified and authorized to discuss the contract herein applied for.

□I have discussed the Owner's life insurance needs and confirm that the policy is appropriate for those needs.

Writing Producer First/Middle/Last Name	
Producer Phone #	Producer Email
Producer Signature	Date (mm/dd/yyyy)

Note: *Complete ONLY if the Second Producer was present at the time of sale.*

Second Producer First/Middle/Last Name	
Second Producer Signature	Date (mm/dd/yyyy)

Split Commissions

Note: *Complete ONLY if more than one producer will receive commission on this sale. Unless otherwise specified, commissions will be shared equally between all producers listed below.*

Writing Producer Name	Producer I.D. #	% Split
Second Producer Name	Producer I.D. #	% Split