

EMPLOYEES LIFE COMPANY (MUTUAL)

LAKE BLUFF, IL 60044-2285 1-800-321-ELCO

Life Insurance Application

Please Print. Use Dark Ink Only.

1. Proposed Insured

Name: *First* *Initial* *Last* Date of Birth *State of Birth* Sex Height Weight

/ /

Home Address: *Number, Street, Apt. #* *City* *State* *Zip*

Social Security Number Day Phone Number Night Phone Number Driver's License Number

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2. Plan of Insurance, Benefits, and Riders

Plan Name/Type: *Single Premium Whole Life* Face Amount: \$ Additional Benefits/Riders: *Include Terminal Illness Rider* Policy Date: / / Date policy to save age? Yes No

Dividend option, if participating. Cash Reduce Premium Purchase Addition Leave on Deposit Automatic Premium Loan? Yes No

3. Owner Information -- (If other than Proposed Insured)

Name: *First* *Initial* *Last* Relationship to Proposed Insured Social Security Number

Address: *Number, Street, Apt. #* *City* *State* *Zip* Phone Number

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4. Beneficiary Designation

Primary: *List Full Name(s), Date(s) of Birth, Relationship to Proposed Insured.*

Contingent: *List Full Name(s), Date(s) of Birth, Relationship to Proposed Insured.*

5. Existing Life Insurance Information

Life Insurance in force? Yes No *If Yes, total amount: \$* Are other applications pending with any company? Yes No

Will this application change or replace any existing life insurance or annuity? Yes No *If Yes, List the company and the policy number.*

6. Health History, Current Health, Personal Physician Information *Answers are not required for Guarantee Issue Plans*

a) Has the Proposed Insured used tobacco in any form during the past 24 months? Yes No

b) In the last five years, has the Proposed Insured received, or is the Proposed Insured now receiving, medical or surgical care or treatment for: cancer, tumor or malignancy; diabetes, heart or circulatory disease or disorder; high blood pressure; alcohol or drug abuse; enlarged lymph nodes; stroke; epilepsy, mental or nervous disease or disorder; or, disease of the blood, kidneys, liver, lung, stomach or intestines? Yes No

c) Has the proposed insured ever been treated or diagnosed by a physician for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive HIV test? Yes No

If 'yes' to any item(s) above, circle condition(s) and give details, including dates and name, address & phone number of each doctor.

d) To the best of your knowledge and belief, is the Proposed insured now in good health and free from any defect or impairment? Yes No

If 'no', list details. If additional space is needed, use a separate sheet. Date, sign and attach to this application.

FRAUD WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

Having read the above statements and answers, I represent that they are true and complete to the best of my knowledge and belief. I understand that this application shall be the basis for and a part of any policy issued: and no agent or person other than an executive officer of the Company may: change or modify any of the printed statements included herein; or, waive any of the Company's rights or requirements.

It is understood and agreed, no insurance shall take effect unless and until: this application is approved at our Home Office; a policy is issued, delivered to and accepted by its owner; and, the first full premium for the policy is paid. All such must occur while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

Signed at: _____ \$ _____ \$ _____
City, State Mode Premium Mode Cash Attached

_____ *Date Signed Proposed Insured's Signature*

_____ *Agent/Witness Signature Agent Code Proposed Owner's Signature (If other than Proposed Insured)*

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EMPLOYEES LIFE COMPANY (MUTUAL)

Notice to Applicant

Lake Bluff, Illinois 60044-2285

Part 1

As a part of our normal procedures for the processing of your application, an investigative consumer report may be obtained in accordance with your authorization. If obtained the report will include information: (1) obtained through personal interviews with your neighbors; your friends; and, others with whom you are acquainted; and (2) as to the proposed insured's: character; general reputation; personal characteristics; and, mode of living, except as may be related directly or indirectly to your sexual orientation.

You have the right, within a reasonable period of time, to make a written request for additional information as to the nature and scope of the report, if made. You also have the right, upon request, to be informed of the name and address of the consumer reporting agency who prepared the report. You may then contact the agency, direct, to, as provided by the statutes of your state of residence: (1) inspect the report; or (2) receive a copy of the report. Please send any requests to us, at our Home Office.

APSF98N (See Part 2 on reverse side.)

MEDICAL INFORMATION BUREAU

**Notice to Applicant
(MIB)**

Part 2

Information regarding your insurability will be treated as confidential. Employees Life Company (Mutual) or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Employees Life Company (Mutual), or its reinsurers, 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.

**EMPLOYEES LIFE COMPANY (MUTUAL)
LAKE BLUFF, IL 60044-2285**

AUTHORIZATION

I AUTHORIZE any of the following that have any records or information regarding the Proposed Insured, including driving records or controlled substance or alcohol abuse, to provide such records or information to Employees Life Company (Mutual), its legal representative(s), or its reinsurer(s): (1) any licensed physician or medical practitioner; (2) any hospital or clinic, medical or medically related facility; or (3) the Medical Information Bureau, consumer reporting agency or other such organization, insurer or reinsurer, employer, institution, government agency or person.

I ALSO AUTHORIZE : (1) all sources stated above except the Medical Information Bureau to provide such information to a consumer reporting agency or other agency employed by Employees Life Company (Mutual) to obtain such information; (2) Employees Life Company (Mutual) or its reinsurers, to release such information: (a) to the Medical Information Bureau; (b) to other insurers in which the Proposed Insured has insurance, to whom the Proposed Insured may apply for insurance or submit a claim; or (c) as may be lawfully required; and (3) Employees Life Company (Mutual) to obtain an investigative consumer report.

I UNDERSTAND THAT: (1) on request, I may receive a copy of this authorization; and (2) the information obtained by use of this authorization will be used: (a) to determine the eligibility of the Proposed Insured for insurance, or (b) to determine eligibility for benefits in the event of a claim.

I AGREE that this authorization, or a copy, shall be valid for a period of 30 months from the date shown below.

Printed Name of Proposed Insured

Date

Signature of Proposed Insured or Parent/Guardian

Witness

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PROXY

Do you hereby constitute and appoint the proxy committee of Employees Life Company (Mutual), as established in the bylaws, as your lawful attorney and proxy and in your name and stead hereby authorize and empower it to cast your vote at any meeting of the policyholders of the company? This proxy shall continue in force except when you are present in person or revoke it by giving the company written notice in accordance with the Employees Life Company (Mutual) bylaws.

Answer Yes No

Proposed Owner's Signature

Signed at: _____ on _____
(City, State) *(Date)*

PROXY 1995

AGENT'S INTERROGATORY

To the best of your knowledge and belief, will the insurance now applied for replace or change any insurance or annuity? Yes No
If yes, comply with any replacement regulations.

Agent's Signature

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