EMPLOYEES LIFE COMPANY (MUTUAL) | **Life Insurance Application**

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

2. Plan of Insurance, Benefits, and Riders

Plan Name/Type:	Face Amount:	Additional Benefits/Riders:	Policy Date:	Date policy to save age?
Single Premium Whole Life	$	***Include Terminal Illness Rider***	/ /	❒ 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 ( )

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? *Proposed Insured:* ❒ Yes ❒ No *Agent:* ❒ 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 diagnosed by a physician as having 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 STATEMENT: Any person who, knowingly and with intent to injure, defraud or or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

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*

Witness (licensed agent): ______________________ Agency code number: ______________________

Agent's printed name: ______________________ Agent's Florida license number: ______________________

APSF98FL *Ed. 01/98*

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*

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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.

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Agent's Signature

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