

**APP 2 Use this application for all risks \$100,000 and OVER**

**WICHITA NATIONAL LIFE INSURANCE COMPANY**

711 SW D Avenue • P. O. Box 1709  
Lawton, OK. 73502

**AMOUNT APPLIED FOR \_\_\_\_\_  
PREMIUM \_\_\_\_\_**

**APPLICATION FOR:**

- Whole Life  Mortgage Protection  
 Annual Renewable Term  Level Term Protection  
 Rider \_\_\_\_\_

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT
OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM

NAME OF PROPOSED INSURED		SOCIAL SECURITY NO.		SEX	AGE	DATE OF BIRTH	
ADDRESS		HOME PHONE		BIRTH STATE		HEIGHT	WEIGHT
CITY, STATE, ZIP		OCCUPATION					
EMPLOYER		YEARS EMPLOYED			BUSINESS PHONE		
ADDRESS		NAME AND ADDRESS OF POLICY OWNER IF NOT PROPOSED INSURED. (IF PAYER IS NOT OWNER, GIVE NAME AND ADDRESS IN "REMARKS")					
CITY, STATE, ZIP							
PRIMARY BENEFICIARY		RELATIONSHIP		CONTINGENT BENEFICIARY		RELATIONSHIP	

**NON-SMOKER ELIGIBILITY**

Have you used tobacco within the past 12 months?  Y  N

**AVIATION, AVOCATION, FOREIGN TRAVEL, AND MILITARY.**

**During the past 3 years** has any proposed insured participated in, or contemplated participation in:

- Flights as a pilot, student pilot, or crew member of an aircraft?  Y  N
- Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos?  Y  N

If "YES" complete aviation or avocation questionnaire.

**Is any change** in residence, occupation or travel outside the U.S.A. or Canada contemplated by any proposed insured?  Y  N

If "YES" explain in the "DETAILS AND REMARKS" section on reverse side.

**Military-is any proposed** insured a member of the Armed Forces or any reserve component?  Y  N

If "YES" indicate **Branch** \_\_\_\_\_ **Rank** \_\_\_\_\_

**HAS ANY PROPOSED INSURED EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION.**

- Heart or circulatory disease, high blood pressure, varicose veins, phlebitis?  Y  N
- Disorder of lungs or respiratory systems, stomach, intestines, or liver?  Y  N
- Disorder of kidneys, or urinary tract, reproductive organs, prostate, or breast?  Y  N
- Arthritis, cancer or tumor, disease of , or injury to neck, back or spine, muscles, joints, sciatica, or bodily deformity?  Y  N
- Disease or impairment of the eyes, ears, or nervous or mental disorder?  Y  N
- Alcoholism or drug usage, not physician prescribed?  Y  N
- Diabetes, thyroid or other endocrine disease?  Y  N
- Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years?  Y  N
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS, the AIDS related complex (ARC) or tested positive for the AIDS virus?  Y  N

**IF ANY OF THE ABOVE QUESTIONS ARE ANSWERED "YES" EXPLAIN BELOW: (ADDITIONAL SPACE ON REVERSE SIDE)**

REASON FOR TREATMENT or CONSULTATION	DATE MO/YR	NAME & ADDRESS of DOCTOR and/or HOSPITAL

NAME AND ADDRESS OF PERSONAL PHYSICIAN \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE AND REASON LAST SEEN \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLAN APPLIED FOR**

PLAN NAME	AMT. OF INS.	RATE	PREMIUM
		X	=
RIDERS		X	=
		X	=

**FAMILY HISTORY:** Has any family member had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?  Yes  No (Circle Condition).

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			

**Is insurance applied** for to replace or change life insurance or annuity in this or any other company?  Y  N

**Has any proposed** insured ever applied for any life, accident, or health insurance which has not been granted as applied for in kind, amount or rate, or has any insurance been cancelled or the renewal or reinstatement thereof been refused?  Y  N

**Is there any application** for life, accident, or health insurance on any proposed insured now pending in any other company?  Y  N

If "YES" give full particulars in the "Details and Remarks" section.

**TOTAL LIFE INSURANCE IN FORCE ON PROPOSED INSURED(S)**

LIFE AMOUNT	\$	TOTAL ADB	\$
ISSUE YEAR	COMPANY	PLAN	AMOUNTS OF INSURANCE LIFE ADB

**WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

**AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT FOR PROPOSED INSURANCE FOR THE APPLICANT**  
**Authorization:** "I/we hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me (us) or my (our) health to give The Wichita National Life Insurance Company, or its reinsurer(s) any such information. NOTICE: Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient there. I/we acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau. A photocopy of this authorization shall be as valid as the "original."

I/we hereby declare that to the best of my/our knowledge and belief the above statements and answers to the above questions are complete and true. I/we agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life(s) of the proposed insured(s). It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured(s) are as described in this application.

PROPOSED INSURED'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 POLICY OWNER IF NOT PROPOSED INSURED \_\_\_\_\_ DATE \_\_\_\_\_

**REQUIRED NOTICE TO APPLICANT**

Details & Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Office Endorsements:

**ASSIGNMENT**

I/WE hereby assign to \_\_\_\_\_, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ .

\_\_\_\_\_  
First Insured

The foregoing assignment is filed at the Company's Home Office this

\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ .

Policy # \_\_\_\_\_  
Wichita National Life Insurance Company

Who is to pay premium?  Insured  Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?  
 YES  NO (if "Yes," explain in "Details and Remarks.")

\_\_\_\_\_  
Soliciting Agent **CASH RECEIVED WITH APPLICATION: LIFE:\$** \_\_\_\_\_

**AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.**

**Procedures For Completing This Life Application — When Applying For:**

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

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PRIMARY BENEFICIARY		RELATIONSHIP		CONTINGENT BENEFICIARY		RELATIONSHIP	

**NON-SMOKER ELIGIBILITY**

Have you used tobacco within the past 12 months?  Y  N

**AVIATION, AVOCATION, FOREIGN TRAVEL, AND MILITARY.**

**During the past 3 years** has any proposed insured participated in, or contemplated participation in:

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RIDERS		X	=
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LIFE AMOUNT	ISSUE YEAR	COMPANY	TOTAL ADB	AMOUNTS OF INSURANCE LIFE	ADB
\$			\$		

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DATE AND REASON LAST SEEN \_\_\_\_\_  
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**NAME AND ADDRESS OF BANK**

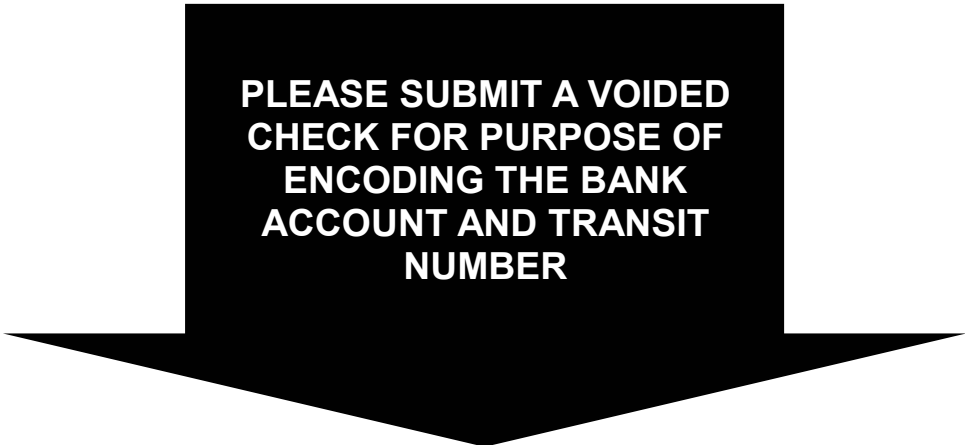
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**AUTHORIZATION TO HONOR CHECKS OR DRAFTS DRAWN BY  
WICHITA NATIONAL LIFE INSURANCE COMPANY,  
LAWTON, OKLAHOMA**

As a convenience to me, I hereby request and authorize you to pay and charge my account checks or drafts drawn on my account by and payable to the order of the Wichita National Life Insurance Company, Lawton, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or draft shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or draft. I further agree that if any such check or draft be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

To Bank			POLICY NUMBERS
Address Of Bank	STREET, CITY, STATE		
	ZIP		
CHECKING ACCOUNT NUMBER		ACCOUNT TITLE IF APPLICABLE	
Bank NOS	TODAY'S DATE	YOUR BANK SIGNATURE	

AN INDEMNIFICATION AGREEMENT IS BELOW — ATTACH VOID CHECK

**INDEMNIFICATION AGREEMENT**

**TO: Bank named above**

In consideration of your participating in a plan which Wichita National Life Insurance Company (hereinafter know as Company) has put into effect by which amounts due on policies of insurance are collected by checks drawn by the Company on the accounts of persons who are responsible for these payments., the Company does hereby agree that:

- (1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payments by you of any check drawn by the Company on the account of such person, or arising out of dishonor by you, whether with or without cause or intentionally or inadvertently, or any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought or be collected by the Company by any check and
- (2) The Company will refund to you any amount erroneously paid by you on any check if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check on which such erroneous payment was made.
- (3) It will defend at its own cost and expense any action which might be brought by any depositor or any other persons because of you actions arising by your participating in the plan of premium collection for the Company.

This indemnification extends to any liability of yours arising out of the dishonor of such a check not only to persons having an account with your bank, but also to any owner or beneficiary of any policy issued by Wichita National Life Insurance Company in respect of which such a check is drawn.

**WICHITA NATIONAL LIFE INSURANCE COMPANY CONDITIONAL RECEIPT**

P.O. BOX 1709, LAWTON, OKLAHOMA 73502

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**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

No coverage will become effective prior to policy delivery and acceptance unless all conditions of this receipt are met. No agent and no broker has the authority to alter the terms or conditions of this receipt or coverage applied for.

Received \$ \_\_\_\_\_ from \_\_\_\_\_ on \_\_\_\_\_ 20\_\_\_\_ in connection with an application for life insurance bearing the same number as this receipt, for \_\_\_\_\_ (Type of consideration for such premium).

IF

1. An amount equal to the first full premium for the mode selected is submitted; and
2. All the underwriting requirements, including any medical examinations required by the company rules, are completed within 60 days from the date of the application; and
3. The proposed insured(s) are, on the Effective date defined immediately below, a risk acceptable for standard insurance **exactly as applied for without modifications of plan, premium rate, or amount** under the company's rules and practices.

THEN: Insurance under the policy applied for shall be considered in force of the effective date. The Effective Date is defined as the latter of:

- A. The date of completion of all underwriting requirements; or
- B. The date of issue requested in the application, if any.

Any check or draft given as the full premium payment must be honored on presentation to constitute a premium payment.

In any event the amount of life insurance including accidental death benefits which may become effective prior to policy delivery shall be \$100,000, or the amount of insurance requested in the application if such amount is less.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET THE LIABILITY TO THE COMPANY IS LIMITED TO THE RETURN OF THE AMOUNT OF PAYMENT SUBMITTED.

I have read and understand the conditions and limitations contained in this receipt.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Witness

**NOTICE TO PROPOSED INSURED — MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Wichita National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, 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 such 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. (Medical information will be disclosed only to your attending physician.) 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 02110, telephone number (617) 426-3660.

Wichita National Life Insurance Company or its reinsurers, may also release information in its file to its reinsurers or to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim or benefits may be submitted.

**NOTICE TO INSURED — FAIR CREDIT REPORTING ACT**

As a part of our underwriting procedure, a routine investigative consumer report may be made during the next few days, whereby information is obtained through personal interview with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This report typically concerns information on your character, general reputation, personal characteristics and mode of living.

Additional information as to the nature and scope of this report, if one is made, will be provided to you upon written request. Should you wish to contact us about questions you may have, please write to:

WICHITA NATIONAL LIFE INSURANCE COMPANY  
P.O. Box 1709 / Lawton, Oklahoma 73502