

Wichita National Life Insurance Co.

711 SW D AVENUE P.O. BOX 1709 LAWTON, OKLAHOMA 73502

SINGLE PREMIUM TERM INSURANCE APPLICATION

SECTION A — Plan and Amount Applied For

Policy Number: _____

Decreasing Term Level Term Insurance Amount \$ _____ Single Premium \$ _____ Term in Years _____

SECTION B — Particulars Pertaining to Proposed Insured

Name of Proposed Insured				Primary Beneficiary	
Address				Relationship	
City, State, Zip				Contingent Beneficiary	
Social Security No.	SEX	Date of Birth	Age (last)	Relationship	
Home Phone	Birth State	Height	Weight	Name and Address of Policy Owner If Not Proposed Insured.	
Business Phone	Occupation				

SECTION C — Particulars Relating to the Risk Evaluation of the Proposed Insured. Give Details to all "Yes" Questions on backside of this page.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. HAVE YOU EVER RECEIVED MEDICAL DIAGNOSIS, CARE OR TREATMENT FOR: (if "yes" circle condition) | | |
| (a) Heart or cardiovascular disease or disorder; Lung or respiratory disease; any blood disease, stroke, high blood pressure, diabetes, cancer or malignancy of any kind; kidney or liver disease; drug or alcohol addiction; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for HIV? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Any deformity, disease, condition or disorder not indicated above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOU TAKING ANY PRESCRIBED MEDICINE(S)? (if so, list drugs — on backside of this page) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DURING THE PAST 3 YEARS HAVE YOU PARTICIPATED IN FLIGHTS OF AN AIRCRAFT AS A CREWMEMBER, (PILOT, STUDENT, FLIGHT ATTENDANT, ETC...)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. IS INSURANCE APPLIED FOR TO REPLACE OR CHANGE LIFE INSURANCE OR ANNUITY IN THIS OR ANY OTHER COMPANY? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

SECTION D — Acknowledgement Statement and Authorization for Proposed Insured or the Applicant

I agree that: (1) the above answers and statements are, to my knowledge and belief, true and complete; (2) the above answers will form the basis for and be part of every policy issued hereunder; (3) the company is not liable for delay in acting on this application; (4) this insurance will take effect on the date the policy is issued by the company if the first premium has been paid and the policy is delivered to me while I am in good health. I understand that any authorization I give the company to draw drafts on my bank account is not payment of the first premium until the draft is drawn, deposited and paid by my bank. (5) No change in amount, rating, plan, issue age, or benefits will be effective unless agreed to in writing by me.

Authorization: "I 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 or my health to give the 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 here. I acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

I acknowledge receipt of the notices attached to this application. I have received the notice of the Fair Credit Reporting Act and the MIB.

DATE ____/____/____ SIGNED AT _____ SIGNATURE _____

SECTION E - Particulars Related to Licensed Agent

This application was completed and signed in my presence on the date written on this page and to the best of my knowledge, this application is not involved in replacement of life insurance or annuities as defined in applicable Insurance Department Regulations.

X _____
SIGNATURE OF PRODUCING AGENT AGENT NO. AGENCY NO.

SPL&D APP (12/08)

CUT ALONG DOTTED LINE

Dec—08

DETACH AND GIVE TO APPLICANT

The notice set forth below is given in compliance with the provisions of Section 606(a) of the Fair Credit Reporting Act.

NOTICE (PART 1): An investigative consumer report may be obtained for information about character, reputation, personal characteristics, and mode of living. Interviews may be with your friends, neighbors, and associates. You have the right to make a written request within a reasonable time to get detailed information about the report.

NOTICE (PART 2): Information regarding you will be confidential. **WICHITA NATIONAL LIFE INSURANCE CO.** or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit organization of life insurance companies which operates an information exchange. If you apply to another Bureau member company for life or health insurance coverage, or send them a claim for benefits, the Bureau will give such company the information in its file. The Bureau will give you information in your file if you request it. (Medical information will be given only to your attending physician.) If you question the information in the Bureau's file, you may contact them and seek a correction in accordance with the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Box 105, Essex Station, Boston, Massachusetts, 02112, telephone number (617) 426-3660. **WICHITA NATIONAL LIFE INSURANCE CO.** or its reinsurers, may also give information to the other companies to whom you may apply for insurance, or send a claim for benefits.

LIST CONDITION, NAME, ADDRESS AND TELEPHONE NUMBER OF DOCTORS, HOSPITALS OR CLINICS CONSULTED AND GIVE DATES AND TYPE OF TREATMENT. LIST PRESCRIBED MEDICATIONS.

Remarks & Details — To "Yes" answers (all "yes" answers must be fully explained— attach an additional sheet if necessary.)

Question #	Condition	Dates	Treatment	Name, Address, and Telephone Number of Doctors, Hospitals or Clinics Consulted

COLLATERAL ASSIGNMENT

For value received, I hereby assign to _____

_____, Assignee, the proceeds including cash values, due or to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me to said assignee. I agree that in the event of any default, assignee is authorized to cancel this insurance and credit any premium refund or cash surrender value toward my indebtedness as his interest may appear.

I also agree that this assignment is irrevocable until all indebtedness due Assignee by me 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_____

Signature of Policyowner

The foregoing assignment is filed at the Company's Home Office this _____ day of _____ 20_____

Policy No. _____

Wichita National Life Insurance Company

by _____

Wichita National Life Insurance Co.

WICHITA NATIONAL LIFE BLDG
711 SW D AVENUE
P.O. BOX 1709
LAWTON, OK. 73502