Wichita National Life Insurance Company

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

SINGLE PREMIUM TERM INSURANCE

A P P L I C A T I O N

SECTION A - Plan and Amount Applied For

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

SECTION B - Particulars Pertaining to Proposed Insured

Name of Proposed Insured				
Address				Primary Beneficiary
City, State, Zip				Relationship
Social Security No.	Sex	Date of Birth	Age	Contingent Beneficiary
Home Phone	Birth State	Height / Weight		Relationship
Business Phone	Occupation			

SECTION C - Particulars Relating to the Risk Evaluation of the Proposed Insured. Give Details to all "Yes" answers in Section F at the bottom 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?	☐	☐
(b) Any deformity, disease, condition or disorder not indicated above?	☐	☐
2. **ARE YOU TAKING ANY PRESCRIBED MEDICINE(s)?** (if so, list drugs—Section F on bottom of page)	☐	☐
3. **DURING THE PAST 3 YEARS HAVE YOU PARTICIPATED IN FLIGHTS OF AN AIRCRAFT AS A CREWMEMBER? (PILOT, STUDENT, FLIGHT ATTENDANT, ETC…)?**	☐	☐
4. **IS INSURANCE APPLIED FOR TO REPLACE LIFE INSURANCE OR ANNUITY IN THIS OR ANY OTHER COMPANY?**	☐	☐

SECTION D - Acknowledgement Statement and Authorization for Proposed Insured

Authorization: "I hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc. 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. I hereby authorize Wichita National Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. **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 MIB, Inc. 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.

X _____ _____
SIGNATURE OF PROPOSED INSURED DATE

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 DATE

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

SECTION F - 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

(3/12)

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 Proposed Insured

The foregoing assignment is filed at the Company's Home Office this _____ day of _____20_____

Policy Number: _____ _____
Wichita National Life Insurance Company

NOTICE TO PROPOSED INSURED — MIB, Inc.

Information regarding your insurability will be treated as confidential. I authorize Wichita National Life Insurance Company or its reinsurers to make a brief report of my personal health information to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for such benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. 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

_____ _____
Signature of Proposed Insured **Date**