Application for Individual Life Insurance

Golden Eagle

Final Expense

FAMILY BENEFIT LIFE INSURANCE CO.

7633 East 63rd Place, Suite 230 Tulsa, OK 74133

Don't leave your family worried about how they will handle your final expenses

Family Benefit Life Insurance Company's **Golden Eagle Final Expense Plan** offers you Peace of Mind regarding your family's financial security by providing cash when it's needed the most.

Peace of Mind and Security.

After the death of a loved one, many families are faced with unexpected expenses: Final Expenses, Legal Fees, Unpaid Bills, Unforeseen Expenses.

Protect your loved ones from the added stress these expenses create by planning ahead with Family Benefit Life Insurance Company's Simplified Issue Whole Life Plan, the Golden Eagle!

Guaranteed Level Premiums: Your premiums are guaranteed for life and do not increase regardless of your age or health.

Guaranteed Death Benefit: Your face amount will never decrease regardless of your age or health. At death, 100% of the death benefit is paid to the beneficiary you name (less any loans you may have outstanding).

Guaranteed Non-Cancelable Policy: Coverage under this policy can never be canceled as long as scheduled premium payments are made.

Affordable Premiums: You choose the amount of coverage that suits both your needs and your budget. If all application questions are answered "NO", you may be eligible for a death benefit of $2,500 - $25,000. A "YES" answer may allow you to be issued a "Graded Death Benefit" policy of $2,000 - $10,000.

100% Accelerated Living Benefit: Benefits may be accelerated if the insured is diagnosed with a terminal illness that with reasonable medical certainty will result in the death of the Insured in 12 months or less.

Nursing Home Confinement: Benefits may also be accelerated if the Insured is confined continuously to a Qualified Nursing Home, with confinement expected to continue until the Insured's death. Nursing Home confinement must begin after the effective date of this policy.

Convenient Billing: You have a variety of payment options from which to choose to make paying your premiums easy and convenient. Select either: annual, semi-annual, quarterly, or monthly automatic deduction directly from your checking or savings account. The choice is yours!

The Golden Eagle is easy to apply for. No Medical Exam!

Leave this page with the Applicant

Application for Individual Life Insurance (Please Print. Use black or blue ink)

Family Benefit Life Insurance Company (FBLIC), 7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133

Telephone Interview Completed: ☐ Yes ☐ No

(888) 995-7722 Order # _____

Section 1:

1. Full Name of Proposed Insured: First _____ MI _____ Last _____

Sex at birth: _____ DOB: ____/____/____ State or Country of Birth: _____ Age: _____ SSN: ____-____-____ Marital Status: _____

Residence Address: _____

Street City State Zip Code

Home Phone: _____ Work Phone: _____ E-Mail: _____

2. Is the Proposed Insured a U.S. citizen? ☐ Yes ☐ No If **No**, is the Proposed Insured a permanent legal U.S. Resident? ☐ Yes ☐ No

Permanent Resident ID # _____ Expiration Date _____

3. Owner (If other than Proposed Insured):

Name _____ SSN or TIN: ____-____-____ Phone: _____

Address: _____ Relationship: _____

Street City State Zip

4. Send Premium Notices to: ☐ Insured ☐ Owner ☐ Other (If Other) Name: _____

Address: _____ Relationship: _____

Street City State Zip

5. Plan Applied For:

☐ Simplified Issued ☐ Graded Benefit	☐ Non-Tobacco ☐ Tobacco	Automatic Premium Loan: ☐ Yes ☐ No	Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT

Face Amount: $ _____ Modal Premium: $ _____ Premium Collected: $_____ or ☐ None-Draft 1st Premium

(Checks Must be made payable to Family Benefit Life Insurance Company)

Issue Month (Jan.-Dec.): _____ Issue Date (1st — 28th): _____ or ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

6. Does the Proposed Insured and/or Owner have any existing life insurance or annuity coverage? ☐ Yes ☐ No

Will any existing insurance or annuity policy with another company be discontinued or changed if the insurance applied for is issued? ☐ Yes ☐ No

(If yes, give details.) Company: _____ Policy #: _____ Coverage Amount: _____ Year Issued _____

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7. Please provide the name of the doctor, practitioner, or health care facility that can provide the most complete and up-to-date medical information regarding the health of the Proposed Insured.

Primary Care Physician or Facility _____

Address: _____

Street City State Zip

Date last seen: _____ Phone: _____

8. Beneficiaries: Percentages for each beneficiary class (Primary and Contingent) must total 100%.

Primary _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

☐ Primary
☐ Contingent _____ Percent: _____ % Relationship _____ Date of Birth _____ SS#: ____-____-____

Additional Information:

Section 2:

Health History:

1. Proposed Insured's Height_____Weight_____ In the Past year any ☐ gain ☐ loss_____lbs.
2. Have you used tobacco, nicotine products, marijuana, electronic cigarette, or vaping pen/device in any form in the past 12 months? ☐ Yes ☐ No
3. Have you ever received or been given medical advice by a medical professional that you need to receive an organ or tissue transplant? ☐Yes ☐No
4. Have you ever been diagnosed or treated by a medical professional as having: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV (Human Immunodeficiency Virus) virus? ☐Yes ☐No
5. Have you ever been diagnosed by a medical professional with a terminal illness, end stage disease, congestive heart failure or cardiomyopathy? ☐Yes ☐No
6. Have you ever been diagnosed by a medical professional for or taken medication for: dementia, Alzheimer's disease, mental incapacity, Downs Syndrome, Huntington's disease, Lou Gehrig's disease (ALS), cystic fibrosis, cerebral palsy, muscular dystrophy, or sickle cell anemia? ☐Yes ☐No
7. Are you currently, or within the past 6 months have you been: hospitalized, bedridden, used oxygen to assist in breathing, confined to a wheelchair, nursing home, hospice, received home health care or been on dialysis? ☐Yes ☐No
8. Within the past 12 months have you been diagnosed by a medical professional for, or been hospitalized for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind (pacemaker, heart valve replaced, bypass, angioplasty, stent implant) to improve circulation to the heart or brain? ☐Yes ☐No
9. Within the past 12 months have you been: hospitalized two or more times, or been advised by a medical professional to have surgery, hospital confinement, or nursing facility confinement and have not done so? ☐Yes ☐No
10. Within the past 24 months have you been diagnosed or treated by a medical professional for, or taken medication for: internal cancer, leukemia, or melanoma? ☐Yes ☐No
11. During the past 24 months have you been: advised by a medical professional to have any diagnostic testing recommended, except for an HIV test, which has not been completed, or for which the results have not yet been received, or had or been advised to have treatment or counseling for alcohol or drug abuse? ☐Yes ☐No
12. During the past 24 months have you been treated by a medical professional for: insulin shock, diabetic coma, amputation caused by disease, or have you ever taken insulin shots prior to age 40? ☐Yes ☐No

If any answers to questions 3-12 are "YES", Proposed Insured is not eligible for any coverage.

13. During the past 24 months have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind (pacemaker, heart valve replaced, bypass, angioplasty, stent implant) to improve circulation to the heart or brain? ☐Yes ☐No
14. Have you ever been diagnosed as having: multiple sclerosis, epilepsy, schizophrenia, Parkinson's, chronic kidney disease or failure, systemic lupus, hepatitis B or C, cirrhosis of the liver, liver disease, liver failure or lung impairments(including chronic obstructive pulmonary disease (COPD), chronic asthma, chronic bronchitis, emphysema or fibrosis)? ☐Yes ☐No
15. Have you ever been diagnosed with diabetes and also been diagnosed with, or been advised by a member of the medical profession to receive treatment for: nephropathy (kidney), neuropathy (nerve), or retinopathy (eye)? ☐Yes ☐No

If any answers to questions 13-15 are "YES", Proposed Insured may qualify for Graded Death Benefit.

Please underline the specific impairment or disease for any question answered yes. Specify question number and provide details below.

ACKNOWLEDGEMENTS: I have read the completed application in its entirety. I agree that this application will be the basis for, and will become part of the policy, if issued. The above representations are true to the best of my knowledge and belief. Any material misrepresentation or misstatement contained herein may render any policy issued as a result of this application void from its inception. I agree the policy shall not be in effect until it has been issued by Family Benefit Life Insurance Company, and the initial premium has been paid. I further agree and understand that no insurance will be effective until the date stated in the policy and provided that there has been no change to the Proposed Insured's health between the date this application was signed, and the issue date of this policy. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions.

I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth, and tax payer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice. ☐Yes ☐No

I acknowledge that I paid the Agent $_____in initial premium in exchange for the Conditional Receipt attached to this application. ☐Yes ☐No

I acknowledge receipt of the Accelerated Benefit Rider Summary and Disclosure Statement. ☐Yes ☐No

FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured:_____Date:_____

Signature of Proposed Owner (if other than Insured):_____Signed at:(City & State)_____

AGENT CERTIFICATION: I certify that I have asked the Proposed Insured all of the questions on this application and have accurately recorded them. I also certify that replacement of existing insurance ☐is or ☐is not involved.

Is any agent a relative of the Proposed Insured? ☐Yes or ☐No Relationship:_____Send Policy to: ☐ Agent or ☐Owner

Agent:_____Agent Code:_____Agent Signature:_____%_____

Agent:_____Agent Code:_____Agent Signature:_____%_____

IMPORTANT NOTICES

Insurance Information Practices:
We will rely primarily on information provided by you. We may supplement that information with information from other sources. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this notice under **Federal Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report. You have the right to be told about, and to see and copy, if you wish, items of personal information about you that appear in our files, including information contained in investigative reports. You also have the right to seek correction of information you believe to be inaccurate.

Federal Fair Credit Reporting Act:
As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living and personal characteristics. The agency will conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB, Inc. Disclosure:
Information regarding your insurability will be treated as confidential. Family Benefit Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of 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 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. If you question the accuracy of information in 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Family Benefit Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Neither Family Benefit Life Insurance Company nor its agents offer tax advice. The information contained in this brochure summarizes the insurance policy and our understanding of current tax laws that relate to this insurance policy. See the policy delivered to you for exact terms, definitions, limitations, exceptions, and conditions. We recommend that you consult with a qualified attorney, accountant, or tax expert for advice regarding your specific situation.

All benefits are contingent upon premiums being paid in a timely manner. Available only to individuals ages 50 – 85 years of age. Product not available in all states. Must meet underwriting requirements and qualifications. Not all applicants will qualify. If a policy is applied for and issued, coverage will not be in effect until approved and the first premium paid. Golden Eagle Final Expense:

Form (FE series) This Base Policy provides the death benefit.

Form (FE ALBR series) This Rider accelerates a portion of the policy's death benefit upon diagnosis of a terminal medical condition or if the Insured is confined continuously to a nursing home.

The benefit in the event of suicide during the first two policy years or allowed by law may be limited to premiums paid. For cost and complete details please contact: **Family Benefit Life Insurance Company, 7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133. www.familybenefitlifeinsurance.com**

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CONDITIONAL RECEIPT

Prior to delivery of the policy, coverage will be effective only when ALL of the following conditions are met:

1. The full first premium according to the mode of payment specified in the application has been tendered and honored for payment.

2. There is no material misrepresentation in the application furnished to the Company.

Subject to satisfactory completion of all of the above conditions, coverage under this receipt will begin on the date the application is signed.

The maximum death benefit and all other supplemental benefits provided by the receipt will be the lesser of: (1) The total death benefit payable under the policy, including any Accidental Death Benefit, on all pending applications with the Company, or (2) $5,000.

If any condition under this receipt is not met, the Company's only liability will be to refund the premium payment. Either the Company or the Proposed Insured may terminate coverage under this receipt by notice to the other.

No agent, broker or medical examiner may waive a complete answer to any question in the application, pass on insurablilty, make or alter any contract or policy provision, or waive any of the Company's other rights or requirements. If there is material misrepresentation in the application (or in any medical or non-medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment. If the Proposed Insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FAMILY BENEFIT LIFE INSURANCE COMPANY. DO NOT MAKE PAYABLE TO AN AGENT OR LEAVE PAYEE BLANK.

Received $_____ **from** _____ **for an**

Application on_____ **dated** _____

Agent Name _____ **Agent Phone Number** _____

FAMILY BENEFIT LIFE INSURANCE CO.

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Tulsa, OK 74133
918-249-2438 • 918-249-2478 fax

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Frankfort, KY 40602-5205
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