



APPLICATION FOR INDIVIDUAL LIFE INSURANCE

IS INSURED A MEMBER OF 1891 Financial Life ("the Organization")? [] Yes [] No

SECTION 1 - Proposed Insured

Form fields for Section 1: First Name, Middle Name, Last Name, Address, City, State, Zip, Primary Phone, Alternate, E-Mail Address, SSN/TIN, Date of Birth, Birthplace, Gender, Occupation, Employer, Annual Income, Total Household Income, Net Worth, Marital Status, The Proposed Insured is a, Driver's License or Government Issued Picture ID, State of Issue, Issue Date, Expiration Date, Has the Proposed Insured's name changed within the past 5 years, Previous full name(s).

SECTION 2 - Replacement Information and Other Insurance

If the answer is YES to any of the following questions, please list information below.

- Has the Proposed Insured applied for any life insurance in the last ninety (90) days?
Does the Proposed Insured have any application (including reinstatement) for life insurance now pending?
Does the Proposed Insured have any existing, pending life insurance, annuity contracts with the Organization or any other company?
a) Is the insurance applied for intended to replace, change, and/or use funds from any life insurance or annuity contracts in force with the Organization or any other company?
b) Will replacement be a Section 1035 Exchange?

Replacement (R), Existing (E), Applied for (A):

Table with columns: (R)(E) or (A), Name of Company, Policy No., Issue Date, Amount, Plan Type, Business (B) Personal (P)

SECTION 3 – Product and Rider

Face Amount \$ _____

PRODUCT TYPE:

Juvenile TERM LIFE

- Plan 1891 Juvenile Smart Term
- Other _____
- Mode Single
- Annual
- Face Amount \$18,910
- \$50,000

Simplified Issue WHOLE LIFE

- Plan Simplified Issue Whole Life
- Simplified Issue Single Premium Whole Life
- Other _____
- Riders Other _____

Ordinary TERM LIFE

- Plan 10-Yr Level Premium Term
- 20-Yr Level Premium Term
- 30-Yr Level Premium Term
- Other _____
- Riders Waiver of Premium
- Accidental Death Benefit \$ _____
- Other _____

Ordinary WHOLE LIFE

- Plan Life Paid Up At Age 100
- Life Paid Up At Age 75
- 20-Pay
- 10-Pay
- Other _____
- Riders Waiver of Premium
- Accidental Death Benefit \$ _____
- Guaranteed Insurability Option \$ _____
- 10-Yr Level Premium Term \$ _____
- 20-Yr Level Premium Term \$ _____
- Other _____

Single Premium WHOLE LIFE

- Plan Single Premium Whole Life
- Other _____
- Riders Guaranteed Insurability Option \$ _____
- Other _____

Other Life _____

Dividend Option for Ordinary Whole Life: Paid in Cash Paid-Up Additions Dividend Accumulation
 Premium Reduction Loan Reduction

Do you elect the Automatic Premium Loan (APL) Provision for Whole Life Plans? Yes No

SECTION 4 –Owner

Owner is: Proposed Insured Other **Owner must be age 18 or older.**

The Proposed Owner is a: Person Trust Entity

IF PERSON:

First Name Middle Name Last Name Gender M F

Address / Apartment Number City State Zip

Primary Phone _____ Alternate _____
Number Type Number Type

E-Mail Address SSN / TIN Date of Birth Relationship to Proposed Insured

The Owner is a: US Citizen US Permanent Resident Years in US _____

Driver's License or Government Issued Picture ID ID# _____

State of Issue _____ Issue Date _____ Expiration Date _____

IF TRUST or ENTITY: Provide a copy of the Trust Certification and Trustee's Powers or Corporate Resolution

Trust/Entity Name Trust Date TIN

Trustee/Officer Name(s)

Address / Apt. No. City State Zip

Primary Phone _____ Alternate _____
Number Type Number Type

E-Mail Address

Relationship to Proposed Insured

SECTION 5 – Payor

Payor is: Proposed Insured Owner Other

The Proposed Payor is a: Person Trust Entity

For **Trust/Entity: use First Name line, with Trust Date and Trustee/Officer Name(s)**

First Name Middle Name Last Name Gender M F

Address / Apartment Number City State Zip

Primary Phone _____ Alternate _____
Number Type Number Type

E-Mail Address SSN / TIN Date of Birth Relationship to Proposed Insured

SECTION 6 – Beneficiary

The beneficiary allocation must total 100% for each class (i.e., Primary and Contingent).

For **Trust/Entity**: use **First Name line, with Trust Date and Trustee/Officer Name(s)**

PRIMARY **CONTINGENT** Percentage _____ %

This Beneficiary is a: Person Trust Entity

_____ Gender M F
First Name Middle Name Last Name

_____ City State Zip
Address / Apartment Number

_____ Type Number Type
Primary Phone Alternate

_____ Relationship to Proposed Insured
E-Mail Address SSN / TIN Date of Birth

PRIMARY **CONTINGENT** Percentage _____ %

This Beneficiary is a: Person Trust Entity

_____ Gender M F
First Name Middle Name Last Name

_____ City State Zip
Address / Apartment Number

_____ Type Number Type
Primary Phone Alternate

_____ Relationship to Proposed Insured
E-Mail Address SSN / TIN Date of Birth

PRIMARY **CONTINGENT** Percentage _____ %

This Beneficiary is a: Person Trust Entity

_____ Gender M F
First Name Middle Name Last Name

_____ City State Zip
Address / Apartment Number

_____ Type Number Type
Primary Phone Alternate

_____ Relationship to Proposed Insured
E-Mail Address SSN / TIN Date of Birth

PRIMARY **CONTINGENT** Percentage _____ %

This Beneficiary is a: Person Trust Entity

_____ Gender M F
First Name Middle Name Last Name

_____ City State Zip
Address / Apartment Number

_____ Type Number Type
Primary Phone Alternate

_____ Relationship to Proposed Insured
E-Mail Address SSN / TIN Date of Birth

SECTION 7 – Medical and Personal History Questions

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.

For YES answers to questions within this Section, please provide details in Section 8 - DETAILS and ADDENDUM.

- 1) The Proposed Insured: Height Ft _____ In _____ Weight _____ lbs.
Any weight changes greater than 10 lbs. in past year? Yes No _____ Lbs. Gain Loss
Reason, check all that apply: Diet Exercise Surgery Pregnancy Unknown
- 2) Name and address of your current medical advisor? _____

a) Date and reason of last visit? _____
b) Was treatment given: Yes No
c) Treatment given: _____
d) Diagnosis: _____
e) Was medication prescribed: Yes No Medication(s): _____
- 3) Has the Proposed Insured currently used any form of tobacco or nicotine products including cigarettes, vaping, cigars, pipes, hookah, chewing tobacco, snuff, nicotine patches or gum? Yes No
a) If yes, last use within: 12 months 1-2 year 3 years
- 4) Travel outside the United States:
a) Has the Proposed Insured travelled within the past 2 years? Yes No
b) Does the Proposed Insured intend to travel and/or reside outside of the United States within the next 2 years? Yes No
- 5) Are you currently active-duty military or have orders/papers to be deployed within the next 12 months? Yes No
- 6) Has the Proposed Insured in the past 5 years:
a) Plead guilty to or been convicted of driving while impaired, intoxicated, or under the influence of any drug? Yes No
b) Plead guilty to or been convicted of 2 or more moving violations? Yes No
c) Had a driver's license suspended or revoked? Yes No
d) Had an application, including reinstatement of such coverage for insurance been declined, rated, postponed, offered with a modification, rescinded, or denied renewal? Yes No
e) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? Yes No
f) Engaged in skydiving, hang gliding, motor sports or racing, rock climbing, parachuting, scuba diving, racing or other hazardous sport or intend to do so in the next 24 months? Yes No
g) Used or currently using marijuana, narcotics, intravenous drugs, cocaine, barbiturates, or hallucinogens, prescribed or not? Yes No
h) Consumed any alcoholic beverage? Yes No
If yes, on average how many alcoholic drinks are consumed per week? 1-12 13-24 over 25
i) Plead guilty to or been convicted of a felony or misdemeanor? Yes No
j) Had or currently have a felony or misdemeanor charge pending against them? Yes No
k) Been on or is currently on probation or parole? Yes No
- 7) Has the Proposed Insured ever been diagnosed, treated, tested positive for, or given medical advice by a member of the medical profession for:
a) Abnormal blood pressure, chest pain, coronary artery disease, abnormal electrocardiogram (EKG), elevated cholesterol, stroke, Transient Ischemic Attack (TIA), peripheral vascular disease or any other disorder or disease of the heart, blood vessels or of the cerebrovascular system? Yes No
b) Cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, malignant melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician? Yes No
c) Diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? Yes No
d) Anxiety, depression, bi-polar, schizophrenia, post-traumatic stress disorder, or an emotional, behavioral, mental, or nervous disorder? Yes No
e) Acquired Immune Deficiency Syndrome (AIDS)? Yes No

- 8)** In the past 10 years, has the Proposed Insured been diagnosed, treated, tested positive for, or given medical advice by a member of the medical profession for:
- a) Auto-Immune disorders, arthritis, lupus, connective tissue disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin? Yes No
 - b) Epilepsy, seizures, brain disorder, dizziness, fainting, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's, cognitive impairment, traumatic brain injury (TBI), motor neuron disease or any other disease or disorder of the nervous system? Yes No
 - c) Symptoms such as: immune deficiency, anemia, recurrent fever, fatigue, or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions, unexplained swelling of the lymph glands? Yes No
 - d) Received counseling or treatment for drug (prescribed or non-prescribed) or alcohol abuse, or been advised by a medical professional to receive treatment or counseling for drug or alcohol abuse? Yes No
- 9)** In the past 5 years, has the Proposed Insured been diagnosed, treated, tested positive for, or given medical advice by a member of the medical profession for:
- a) Any ear, nose, throat, lung disease or disorder, or any respiratory disease or disorder, to include asthma, Chronic Obstructive Pulmonary Disorder (COPD), emphysema, bronchitis, tuberculosis, or sleep apnea? Yes No
 - b) Any disorder of the stomach, intestines, rectum, liver, or pancreas, kidney, or bladder, including ulcers, colitis, Crohn's Disease, celiac disease, or diverticulitis? Yes No
 - c) Any disorder of the prostate, reproductive organs, breast, menstruation, or pregnancy? Yes No
- 10)** In the past 5 years has the Proposed Insured been treated, examined, or advised by a member of the medical profession for any reason not already identified? Yes No
- 11)** In the past 5 years has the Proposed Insured been advised by a member of the medical profession to have any operation, treatment, or diagnostic tests that have not been performed? Yes No
- 12)** In the past 2 years has the Proposed Insured had any diagnostic tests such as an electrocardiogram (EKG), treadmill test, heart catheterization, X-ray, MRI, CT scan, mammogram, or laboratory test? Yes No

Relationship	Age at Death	Age if Living	Diagnosis or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

SECTION 8 – Details and Addendum

REMARKS: Explanations and/or special requests. Addendum for additional details.

SECTION 9 – Agreement – Authorization – Acknowledgement

We, the Proposed Insured, and Proposed Owner, have read this application for life insurance including addendum, any amendments, questionnaires, and supplements and, to the best of our knowledge and belief, all statements are true and complete.

AGREEMENT: We also agree to the following:

- 1) I will comply with all laws and rules of the Constitution and Laws of the Organization.
- 2) Statements in this application and any amendment(s), paramedical/medical exam, addendum, and supplements are the basis of any certificate issued.
- 3) This application and any amendment(s), paramedical/medical exam, addendum, and supplements to this application will be attached to and, along with the articles of incorporation and bylaws of the Organization, become part of the new Certificate, and any copy or electronic image of these documents are as valid as the original and may be relied upon by the Organization in determining whether to issue the insurance for which I applied.
- 4) No information will be deemed to have been given to the Organization unless it is stated in this application and any amendment(s), paramedical/medical exam, addendum, and supplements.
- 5) The Organization will have no liability under this application unless and until: (a) it has been received and approved by the Organization; (b) the Certificate has been issued and delivered to the Certificate Owner; (c) the first premium has been paid to and accepted by the Organization or authorization to draft first payment has been given and the financial institution has not notified the Organization that the draft will not be honored; and (d) at the time of delivery and payment, the facts concerning the insurability of the Proposed Insured are as stated in this application.
- 6) Only authorized officers of the Organization may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application or Certificate.
- 7) Corrections, additions, or changes to the application may be by the Organization. Any such changes will be shown under "Corrections and Amendments". Acceptance of a Certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan amount, or benefits unless agreed to in writing by the Owner.
- 8) I authorize the Organization to communicate with me regarding my insurance or membership via phone, text, email, or mail.

AUTHORIZATION: I, the Proposed Insured, or Parents, if a minor, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, laboratory, pharmacy, pharmacy benefits manager, insurance support organization, government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person having knowledge of me or my health to release all information about me to the Organization, its Medical Director, or its reinsurer(s), for underwriting or claims purposes. I further authorize the release of any information obtained to other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required.

I authorize 1891 Financial Life or its Reinsurers to make a brief report on my personal health information to MIB, Inc.

I understand that the information in my health/medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndromes (AIDS). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This authorization also includes information relating to any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I understand that after this information is disclosed, the recipient may re-disclose it resulting in the loss of protection under federal rules governing privacy and confidentiality.

I agree that a photographic or electronic copy of this authorization will be as valid as the original and that it will be valid for 24 months from the date shown below or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery if shorter than 24 months. This authorization will survive the Insured's death if it occurs while the authorization is in effect. I know that I or my representative may request a copy of this authorization.

I understand I may revoke this authorization at any time by sending written notice to 1891 Financial Life at 200 N. Martingale Rd., Suite 405, Schaumburg, IL 60173. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action was taken prior to receipt of notice of revocation.

If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation.

I may refuse to sign this authorization and understand that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGEMENT

Receipt of Notice of Information Practices; Fair Credit Reporting Act Notice; Notification Regarding MIB, Inc.; eDelivery Consent Disclosure; Privacy Policy.

__ I consent to receive Electronic Communications in the manner described above, and I confirm that any email address or mobile phone number(s) I have provided to 1891 Financial Life are active and valid. I also confirm that I am authorized to consent on behalf of all the other account owners, authorized signers, authorized representatives, delegates, and/or service users identified with 1891 Financial Life.

__ I DO NOT consent to receive Electronic Communications in the manner described above.

STATE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

1891 Financial Life is licensed to do business as a fraternal benefit society. As such, it is not included in any state's life and health guaranty association (otherwise known as the guaranty association). This means that fraternal benefit societies cannot be assessed for the insolvency of other life insurers or other fraternal benefit societies. By law, a fraternal benefit society is responsible for its own solvency. If there is an impairment of reserves, a certificate holder may be assessed a proportionate share of the impairment. This process is described in the certificate issued by the Organization.

FRAUD NOTICE/WARNING

For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed at _____, _____ Date
City State application taken

Proposed Insured Name
(If 18 or Older)

Signature Proposed Insured

Parent/Guardian Name
(If Proposed Insured is a Minor)

Signature Parent/Guardian

Proposed Owner Name
(If Other than Proposed Insured)

Signature Proposed Owner

Trustee/Officer Name
(If Other than Proposed Insured)

Signature Trustee/Officer

Proposed Payor Name
(If Other than Proposed Insured or Owner)

Signature Proposed Payor

Insurance Producer Name

Signature Insurance Producer

Insurance Producer NPN Number

Insurance Producer 1891 Financial Life Agent Code

SECTION 10 – NOTICES – Insurance Information and Privacy

MUST BE GIVEN TO THE PROPOSED INSURED

NOTICE OF INFORMATION PRACTICES

1891 Financial Life will need to collect information about you to issue an insurance policy. You are our most important source of information. We may supplement that information with information from other sources such as medical professionals who have treated you. We may also ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained below under Federal Fair Credit Reporting Notice.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and receive copies of items of information we collect that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send a written request to:
1891 Financial Life at 200 N. Martingale Rd., Suite 405, Schaumburg, IL 60173.

FAIR CREDIT REPORTING ACT NOTICE

In making this application, it is understood that we may obtain information through an investigative consumer report. An independent source known as a consumer reporting agency will prepare the report. The report typically includes information as to your character, general reputation, personal characteristics, and mode of living. The agency may conduct personal interviews with your family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted to get information for the report.

If you write to us within a reasonable period after you receive this notice, we will tell you whether a report was requested. If a report was requested, we will provide you with the name, address, and telephone number of the consumer reporting agency conducting the report. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect the report and to receive a copy of the report, you may contact the consumer reporting agency directly.

NOTIFICATION REGARDING MIB, Inc. (“MIB”)

Information regarding your insurability will be treated as confidential. 1891 Financial Life or its Reinsurer(s), may, however, make a brief report thereon to MIB, a non-for-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 benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website, www.mib.com. 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 is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

1891 Financial Life, or its Reinsurer(s), may also release information in its files 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.

eDELIVERY CONSENT DISCLOSURES

To receive, print, and view your documents, you must provide a valid email address and have internet access and portable document format (PDF) viewing software, such as Adobe Reader.

DOCUMENTS

- a) You will receive an email notification containing a link to a publicly available electronic version of the document that can be viewed, printed, or saved.
- b) The documents do not contain personal information.
- c) Examples of documents you do not log in to view include prospectuses, annual reports and the annual Privacy Notice.

INSERTS

- a) Notification for any documents may include links to inserts that would otherwise be sent with the document if delivered via U.S. mail. You will not be required to log in if the insert is publicly available or if you do not have a log in. Examples of inserts include annual Privacy Notice, prospectus supplements, and other documents.

DOCUMENT AVAILABILITY

Your voluntary consent will apply to:

- a) Any product with which you have a relationship now or while your consent is in effect; and
- b) Any document 1891 Financial Life is legally permitted to send via eDelivery.

1891 Financial Life may, at its discretion, mail paper documents. Depending on the relationship you have with 1891 Financial Life, 1891 Financial Life may allow you to choose eDelivery of specific documents. 1891 Financial Life reserves the right to discontinue this type of offering in the future.

The length of time your electronic documents are available online may vary by product and document. The length of time will never be less than legally required.

REVOKE eDELIVERY OR REQUEST PAPER COPIES

1891 Financial Life will act upon your voluntary eDelivery consent until you revoke it. You may revoke your eDelivery consent and receive documents by U.S. mail at any time without penalty. 1891 Financial Life accepts notification of revocation through any of the Contact 1891 Financial Life options listed. Revocations will be processed within 7 days or sooner as required by law. On some products, 1891 Financial Life may discontinue waiving certain contractual fees or charges if you revoke your eDelivery consent. However, you will not incur a separate charge or fee for receiving paper documents. Revocation does not change the effectiveness, validity, or enforceability of documents previously provided to you by eDelivery.

You may request paper copies of any document you previously received by eDelivery without revoking your eDelivery consent. 1891 Financial Life will provide these documents to you free of charge.

If 1891 Financial Life is unable to successfully eDeliver your documents, 1891 Financial Life will contact you by U.S. mail with further instructions. 1891 Financial Life may deem unsuccessful eDelivery of your documents as a revocation of consent for eDelivery.

CONTACT 1891 FINANCIAL LIFE

You must notify 1891 Financial Life when your contact information changes or you wish to revoke your consent. You may use any of the following methods to update your email address, residential address, or phone number(s), or to revoke your consent:

Call 800-344-6273:

- a) A member service professional will be happy to update your contact information.
- b) For details about the documents currently available by eDelivery.
- c) To request a paper copy of a document you received by eDelivery.

Send a Written Request:

1891 Financial Life
200 N. Martingale Rd. Ste. 405
Schaumburg, IL 60173

CHANGES TO THESE eDELIVERY CONSENT DISCLOSURES

1891 Financial Life reserves the right to modify these eDelivery Consent Disclosures. You will receive an email notification prior to the effective date of any modified eDelivery Consent Disclosures. The email will include instructions to change your consent if you prefer to receive any document(s) by U.S. mail or do not agree to the new eDelivery Consent Disclosures. Any modification of the eDelivery Consent Disclosures will apply from the effective date forward and not to documents you previously received.

PRIVACY POLICY

PROTECTING YOUR PRIVACY IS VERY IMPORTANT TO 1891 FINANCIAL LIFE

This notice summarizes the privacy policy and information practices of 1891 Financial Life (the "Organization"). We have strict policies and procedures in place to safeguard your personal data. Our employees and agents are required to comply with our established policies and procedures. We maintain physical, electronic, and procedural safeguards to protect your personal information from being accessed by unauthorized persons.

INFORMATION WE MAY COLLECT We may collect certain nonpublic personal information about you. This allows us to underwrite and administer your insurance coverage, inform you of other programs and benefits that may be of interest to you and comply with legal and regulatory requirements. The information we collect depends on the products or services you request and may include information such as:

- a) Information we receive from you on an application or other form such as your name, address, age, residence, marital status, social security number, income, and assets.
- b) Information we receive from a consumer-reporting agency, such as credit history.
- c) Information about your past transactions with us such as the products you have purchased, your contract values, and your payment history.
- d) Information from outside parties to verify representations made by you such as employment information, medical information, health history, other insurance coverage, or public records.
- e) General information about you such as your email address, demographic information, avocations, and other personal characteristics.

HOW WE USE AND DISCLOSE YOUR INFORMATION We do not share your information with other organizations except as permitted by law. For example, we may share your information with other individuals or organizations to help underwrite your insurance, process applications, or administer claims, help detect fraud or criminal activity, or assist us in providing benefits to you as a part of your membership. We may also share your information with sales agents and independent brokers who are authorized by the Organization; to marketing organizations or mailing companies to assist us in communicating with and providing service to you. We may also be required to comply with an information request by a government entity or regulator. If we need to share your nonpublic personal information with an affiliated institution or any third-party non-affiliates, we require that they provide the same level of confidentiality and protection.

We do not sell lists of names and addresses of our members to any vendor for goods or services. Our privacy policy also extends to former members who no longer have coverage with the Organization.

We may share personal information such as names, addresses, and Court and Impact Team function photos, with our related fraternal Courts and Impact Teams for fraternal purposes (such as sending you information about Court meetings and events, volunteer activities, the 1891 Financial Life magazine, etc.).

Keeping your information accurate and up to date is very important to us. If you determine that any information, we have for you is incorrect, please contact us so that it may be corrected. Call: Customer Care (800) 344-6273.

CONTACT US WITH QUESTIONS If you have any questions about our Privacy Policy or our information practices, you may contact the Privacy Officer at:

CCPAREQUEST@1891FinancialLife.com, or (872) 263-2460, or write us at the address below.

1891 Financial Life
Attn: Privacy Officer
200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173

17PP-PRIVACY 2/21

ELECTRONIC OPT-IN CONSENT AND DISCLOSURE AGREEMENT

For the purposes of this consent form, “you” and “your” means the proposed Owner/Insured/Annuitant and “we, “us”, “our” and “the Society” means 1891 Financial Life and its successors and agents.

Conducting business with the Society electronically includes signing and receiving documents electronically. You are not required to conduct business with the Society electronically.

Please read this document carefully prior to providing your consent.

If you consent, the Society will transmit documents related to your policy life insurance/annuity by electronic means, to the extent that electronic transmission is consistent with applicable state and federal law. Any document that we send by electronic means, which complies with applicable law, will have the same force and effect as if that document was sent in paper format.

You are consenting to the receipt of electronic documents in connection with an application for insurance and documents which may be sent to you as the owner of a policy. This includes, but is not limited to, current and future legal and regulatory disclosures, notices, correspondence, and other materials, permitted by law to be sent electronically.

The Society will only transmit documents to you electronically if you consent. Your consent is voluntary. If the policyholder or insured or owner has permitted electronic transmissions in the past, that authorization does not obligate the same procedure regarding this policy as well.

If you decide that you want to receive documents electronically, we will provide one paper copy per year of any document, at no charge to you, upon your request.

You can change your mind at any time and have us transmit documents via paper mail by notifying us by any one of the methods below.

If you wish to correct or change the email address the Society uses to send you documents, you can do so at any time by notifying us by any one of these methods:

- email to info@1891financiallife.com, or
- telephone to 1-800-344-6273, or
- paper mail to 200 N. Martingale Rd. Ste 405, Schaumburg, IL 60173.

The Society’s website is www.1891financiallife.com.

For purposes of receiving electronic transmission of documents from The Society, as set forth above, my email address is:

____ I consent to receive electronic transmission of documents. Signature: _____

You should print or save a copy of this Agreement for your records and for future reference.



financial life

A Fraternal Benefit Society

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

ENDORSEMENT

This Endorsement is made a part of the application to which it is attached and is effective at the time of application. This Endorsement hereby deletes the fraud warning in the application and replaces it with the following:

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

This Endorsement is subject to all the terms and conditions of the application. Except as expressly provided herein, the application remains the same.

For 1891 FINANCIAL LIFE:

Handwritten signature of Margaret Schmitt in black ink.

Margaret Schmitt
Board Chair

Handwritten signature of Lisa M. Bickus in black ink.

Lisa Bickus
CEO

FILE THIS ENDORSEMENT WITH YOUR INSURANCE CERTIFICATE



financial life

A Fraternal Benefit Society

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

CERTIFICATE PAYMENT OPTIONS

Certificate Number: _____ **Insured:** _____

Payor's Full Name: _____

Address / Apt. No: _____

City: _____ State: _____ ZIP: _____

Primary Phone No: _____ Email: _____

Premium Amount: \$ _____ **Payment Type:** Electronic Funds Transfer **OR** Debit/Credit Card

Payment Frequency Monthly Quarterly Semi-Annual Annual Single Premium

Premium payments will be drafted within seven (7) days after application approval.

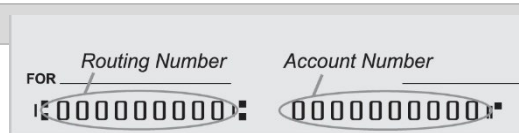
Dates NOT available for premium payment: 29th – 30th – 31st

The premium will be automatically drafted each billing cycle. No notice will be sent when drafted.

Electronic Funds Transfer (EFT)

Please Attach a Copy of a Voided Check to Verify Account Number Accuracy.

Account Type: Checking Savings



Financial Institution _____ Bank Routing Number _____ Account Number _____

Debit/Credit Card

Name on the Card _____ Account Number _____ Expiration Date _____ CVV/CSV _____

Authorization

I (we) request and authorize 1891 Financial Life ("the Organization") to obtain premium payment of amounts becoming due the Organization or amounts as scheduled and requested by the policyowner/payor by initiating charges to my (our) account in the form of checks, drafts, share drafts, or electronic debit entries, credit card and I (we) request and authorize the financial institution named above to accept and honor the same and charge the same to my (our) account. This Authorization will remain in effect until I (we) notify the Organization or financial institution in writing to terminate and the Organization or the financial institution has a reasonable time to act on the termination. This Authorization will become effective only upon acceptance by the Organization of approval of this life insurance policy. The Organization address 200 N. Martingale Rd., Ste. 405, Schaumburg, IL 60173. 1891 Financial Life reserves the right to discontinue this program at any time.

Payment Terms and Conditions

The Organization will have no liability under this application unless and until: (a) it has been received and approved by the Organization; (b) the Certificate has been issued and delivered to the Certificate Owner; (c) the first premium has been paid to and accepted by the Organization or authorization to draft first payment has been given and the financial institution has not notified the Organization that the draft will not be honored; and (d) at the time of delivery and payment, the facts concerning the insurability of the Proposed Insured are as stated in this application. The Proposed Insured, Owner, or Payor will not receive any premium notices.

ACCOUNT OWNER SIGNATURE _____ DATE _____



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A Fraternal Benefit Society

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

PRODUCER'S REPORT

Provide details in Field Underwriting Remarks, section below.

1) Source of Business:

- Currently Insured: plan type _____
- Personal acquaintance (not Proposed Insured)
- Other: _____
- Cold call
- Referral from outside agency
- Internet source
- Reply to mailer or stuffer

2) Market Type:

- Existing customer
- Women's markets
- Family markets
- Business owner
- Multicultural markets
- Alternative markets
- Social media
- Families with special needs
- Other: _____

3) The death benefit amount was determined by: (check all that apply)

- Needs analysis software
- Multiple of income
- Cost of final expense
- Insured
- Other: _____

4) Rate class quoted: _____

5) Applicant and Sales Process:

- a) Did you give the Applicant the Privacy Policy and other disclosures in Section 10? Yes No
- b) Are you related to the Insured? Yes No
- c) Was this application taken in person? Yes No
- d) Was the Proposed Insured present at the time of application? Yes No
- e) Do you know anything not disclosed which might affect the underwriting of this risk? Yes No
- f) Is there another application currently pending or being submitted to any other life insurance company? Yes No
- g) Has any Insured applied elsewhere for any insurance coverage within the past 6 months? Yes No
- h) Is replacement of existing insurance involved in this application? Yes No
If Yes, submit the appropriate replacement forms.
- i) Did you ask the Applicant all the questions on this application and accurately record them? Yes No

6) If the Insured is age 0-16, please answer questions below:

- a) Number of brothers _____, sisters _____.
Does the parent or guardian have at least two times the insurance of the Proposed Insured? Yes No
- b) Amount of life insurance in force and/or requested on
father: \$ _____ and mother \$ _____
sibling 1: \$ _____ sibling 2: \$ _____ sibling 3: \$ _____

I certify I have accurately recorded all information given by the Insured and my statements on this Producer's Report are correct to the best of my knowledge.

Date

_____ Insurance Producer	_____ Signature Insurance Producer	_____ 1891 Financial Life Agent Code	_____ Split	_____ %
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_____ Insurance Producer	_____ Signature Insurance Producer	_____ 1891 Financial Life Agent Code	_____ Split	_____ %
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PRODUCER'S UNDERWRITING REMARKS: Did you notice anything while completing the application with the applicant?



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IMPORTANT NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

APPLICANT SIGNATURE

AGENT SIGNATURE

DATE



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REPLACEMENT POLICY COMPARISON

	EXISTING POLICY A	EXISTING POLICY B	PROPOSED CERTIFICATE
Company Name			
Product Name			
Policy Number			
Issue Date			n/a
Underwriting Class			n/a
Face Amount			
Estimated Current Death Benefit (If other than face amount shown above)			
Premium Annualized			
Type of Product			
Policy Fee Charge (front end load)			
As a % of Premium			
Total Cash Value (Whole) or Total Accumulated Value (Variable or UL)			
Surrender Charge Period			
Estimated Surrender Charges for Existing Policy			
Loan Interest Rate			n/a
Existing Policy Loan Amount			
Is the Replacement a 1035 Exchange?			n/a
Is there a gain in the existing policy? (If yes, please provide amount)			n/a

The PRIMARY reason for purchasing the new life insurance certificate is (be specific). _____

The existing life insurance policy cannot meet the owner's objectives because (be specific). _____

Insurance Producer's Certification. I certify that I have discussed the advantages and disadvantages of replacement with the owner, and that I have determined replacement is appropriate for the owner.

Insurance Producer's Signature

Insurance Producer's Printed Name

Date

Owner's Acknowledgement. I have reviewed and understand the potential advantages and disadvantages of replacing my current policy and I wish to proceed with replacing my current policy. If this replacement involves a loan or partial surrender from an existing policy, this will result in a reduction in values in my existing policy. In addition, with respect to life insurance policies, loans or partial surrenders may result in additional payments being required to keep my existing policy in force. Policy loans also reduce the available death benefit and incur interest charges.

Owner's Signature

Owner's Printed Name

Date

Date of Birth



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CALIFORNIA SENIOR SALES PRESENTATION California Disclosure Notice Checklist

- ✓ *Required when the proposed owner is a California resident who is age 65 and over.*
- ✓ *Use this checklist to ensure clients have received all notices required under California law.*
- ✓ *ALWAYS retain copies of all documents in your files.*

Confirm the required Form was provided to Owner(s) age 65 and over:

_____ Provided all clients age 65 and over with the “Disclosure to Individuals Age 65 or Older”
Form 12NO-SSP-CA.

_____ When setting up an appointment to be conducted in the home of a CA resident age 65 or over, provided “Senior Notice: Your Rights Regarding In-home Meetings” at least 24 hours in advance.
Form 12FM-SSP-CA.

_____ Provided all clients age 65 and over considering purchasing this investment based on its treatment under Medi-Cal with the “Notice Regarding Standards for Medi-Cal Eligibility and Recovery”. This form must be signed and returned with the application.
Form 12NO-SSP-Medi-Cal.



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CALIFORNIA SENIOR SALES PRESENTATION Disclosure to Individuals Age 65 or Older

Required under Section 789.8b of the California Insurance Code

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of an annuity may have tax consequences, early withdrawal penalties, or other costs or penalties, as a result of the sale or liquidation.

You or someone on your behalf may wish to consult independent legal, tax, or financial advice before selling or liquidating any assets and prior to the purchase of any life insurance or annuity products being solicited or offered for sale.



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CALIFORNIA SENIOR SALES PRESENTATION **Notice Regarding Standards for Medi-Cal Eligibility and Recovery**

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than \$130,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of \$35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

MARRIED RESIDENT

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than \$267,400 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or \$3,435 in monthly income, whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$267,400 in countable resources. The order also may allow the at-home spouse to retain more than \$3,435 in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

- *One principal residence.* One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- *Real property used in a business or trade.* Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- *IRAs, KEOGHs, and other work-related pension plans.* These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal property used in a trade or business.*
- *One motor vehicle.*
- *Irrevocable burial trusts or irrevocable prepaid burial contracts.*

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

PLEASE NOTE: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

PROPOSED OWNER SIGNATURE

DATE

SPOUSE'S SIGNATURE

DATE

LEGAL REPRESENTATIVE SIGNATURE, IF ANY

DATE