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

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

IS INSURED A MEMBER OF 1891 FINANCIAL LIFE ("the Organization")? ☐ Yes ☐ No

SECTION 1 – Proposed Insured

First Name _____ Middle Name _____ Last Name _____

Address / Apartment Number _____ City _____ State _____ Zip _____

Primary Phone Number _____ Type _____ Alternate Number _____ Type _____

E-Mail Address _____ SSN / TIN _____ Date of Birth _____ Birthplace _____ Gender ☐ M ☐ F

Occupation _____ Employer _____ $ Annual Income _____ $ Total Household Income _____ $ Net Worth _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Civil Union/Domestic Partnership

The Proposed Insured 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 _____

Has the Proposed Insured's name changed within the past 5 years: ☐ Yes ☐ No

Previous full name(s):

First Name _____ Middle Name _____ Last Name _____

Purpose for insurance coverage: _____

SECTION 2 – Replacement Information and Other Insurance

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

1) Has the Proposed Insured applied for any life insurance in the last ninety (90) days? ☐ Yes ☐ No

2) Does the Proposed Insured have any application (including reinstatement) for life insurance now pending? ☐ Yes ☐ No

3) Does the Proposed Insured have any existing, pending life insurance, annuity contracts with the Organization or any other company? ☐ Yes ☐ No

4) 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? ☐ Yes ☐ No

b) Will replacement be a Section 1035 Exchange? ☐ Yes ☐ No

Replacement (R), Existing (E), Applied for (A): Business (B) Personal (P)

(R)(E) or (A)	Name of Company	Policy No.	Issue Date	Amount	Plan Type	

SECTION 3 – Product and Rider

Face Amount $_____

PRODUCT TYPE:

Juvenile TERM LIFE

Plan
- ☐ 1891 Juvenile Term
- ☐ Other _____

Mode
- ☐ Single
- ☐ Annual

Face Amount
- ☐ $18,910
- ☐ $50,000

Simplified Issue WHOLE LIFE

Please use separate application: Form ICC23AP-LIFE-SI

Ordinary TERM LIFE

Plan
- ☐ 10-Yr Level Premium Term
- ☐ 20-Yr Level Premium Term
- ☐ 30-Yr Level Premium Term
- ☐ Other _____

Riders
- ✓ Living Benefit Rider, Qualifying Event/Terminal Illness
- ☐ Waiver of Premium
- ☐ Accidental Death Benefit $_____
- ☐ Other _____

Ordinary WHOLE LIFE

Plan
- ☐ Life Paid Up At 100
- ☐ Life Paid Up At 75
- ☐ 20-Pay
- ☐ 10-Pay
- ☐ Other _____

Riders
- ✓ Living Benefit Rider, Qualifying Event/Terminal Illness
- ☐ Waiver of Premium
- ☐ Accidental Death Benefit $_____
- ☐ Guaranteed Insurability Option $_____
- ☐ 10-Yr Level Premium Term $_____
- ☐ 20-Yr Level Premium Term $_____
- ☐ Charitable Rider: _____%
  Name of Charity _____
- ☐ Other _____

Single Premium WHOLE LIFE

Plan
- ☐ Single Premium Whole Life
- ☐ Other _____

Riders
- ✓ Living Benefit Rider, Qualifying Event/Terminal Illness
- ☐ Guaranteed Insurability Option $_____
- ☐ Charitable Rider: _____%
  Name of Charity _____
- ☐ 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 Number _____ Type _____ Alternate 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 Number _____ Type _____ Alternate 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 Number _____ Type _____ Alternate 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

First Name ____ Middle Name ____ Last Name ____ Gender ☐ M ☐ F

Address / Apartment Number ____ City ____ State ____ Zip ____

Primary Phone ____ Number ____ Type ____ Alternate ____ Number ____ Type ____

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

☐ **PRIMARY** ☐ **CONTINGENT** Percentage ___________%

This Beneficiary is a: ☐ Person ☐ Trust ☐ Entity

First Name ____ Middle Name ____ Last Name ____ Gender ☐ M ☐ F

Address / Apartment Number ____ City ____ State ____ Zip ____

Primary Phone ____ Number ____ Type ____ Alternate ____ Number ____ Type ____

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

☐ **PRIMARY** ☐ **CONTINGENT** Percentage ___________%

This Beneficiary is a: ☐ Person ☐ Trust ☐ Entity

First Name ____ Middle Name ____ Last Name ____ Gender ☐ M ☐ F

Address / Apartment Number ____ City ____ State ____ Zip ____

Primary Phone ____ Number ____ Type ____ Alternate ____ Number ____ Type ____

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

☐ **PRIMARY** ☐ **CONTINGENT** Percentage ___________%

This Beneficiary is a: ☐ Person ☐ Trust ☐ Entity

First Name ____ Middle Name ____ Last Name ____ Gender ☐ M ☐ F

Address / Apartment Number ____ City ____ State ____ Zip ____

Primary Phone ____ Number ____ Type ____ Alternate ____ Number ____ Type ____

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

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 REMARKS and ADDENDUM Section 8.

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 intend to do so in the next 24 months? ☐ Yes ☐ No
f) Engaged in skydiving, hang gliding, motor sports or racing, rock climbing, parachuting, scuba diving, racing 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) Have you plead guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No
j) Have you and or do you currently have a felony or misdemeanor charge pending against you? ☐ Yes ☐ No
k) Have you been or are you 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) Human Immunodeficiency Virus (AIDS virus) or 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, excluding tests related to the Human Immunodeficiency Virus (AIDS virus), 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 catherization, X-ray, MRI, CT scan, mammogram, or laboratory test, except those related to the Human Immunodeficiency Virus (AIDS virus)? ☐ 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) or human immunodeficiency virus (HIV). 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., Ste. 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
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.

Signed at _____, _____ _____
City State application taken Date

_____ _____
Proposed Insured Name Signature Proposed Insured
(If 18 or Older)

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

_____ _____
Proposed Owner Name Signature Proposed Owner
(If Other than Proposed Insured)

_____ _____
Trustee/Officer Name Signature Trustee/Officer
(If Other than Proposed Insured)

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

_____ _____
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., Ste. 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

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

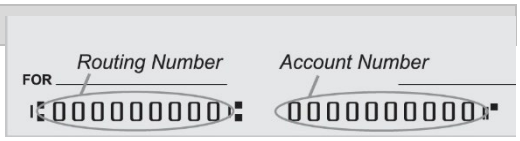
Payment Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Premium

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

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

1891 FINANCIAL LIFE MEMBERSHIP

You are joining a unique member-owned organization. You are more than a customer, you become a member of our Organization. You have a set of member benefits that also includes the opportunity help build stronger communities by supporting service projects that reflect common shared values.

TO BE COMPLETED BY THE PROPOSED INSURED

I am age 16 or older and am applying for membership with 1891 Financial Life.

_____ _____ _____
First Name Middle Name Last Name

_____ _____ _____ _____
Address / Apartment Number City State Zip

Primary Phone _____ _____ Alternate Phone _____ _____
Number Type Number Type

_____ _____ Gender ☐ M ☐ F
Email Address Date of Birth

PUBLICATIONS

Members receive a quarterly newsletter with messages from the CEO and Outreach, or they can view an e-magazine on our website with expanded outreach coverage like scholarship winners, member events and photos, and articles about life insurance and finance.

SURVEY

For survey purposes please select from one of the following:

☐ I am Catholic
☐ I am a spouse of a Catholic
☐ I am not Catholic

MISSION

1891 Financial Life is a community-based insurance organization that offers products and member benefits that assist individuals and their families in achieving financial security, while helping to build stronger communities by supporting service projects that reflect common shared values.

I support the purposes of 1891 Financial Life as described in the Articles of Incorporation as well as its Mission and will comply with the Bylaws of 1891 Financial Life. I also verify that the information I provided is true and correct.

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CHARITABLE GIVING RIDER
APPLICATION

1) Insured

First Name: _____ Middle: _____ Last: _____

Phone: _____ Email:_____

☐ I would like my donation to be anonymous.

2) Qualified Charitable Organization[1]

Name: _____

Address: _____

City: _____ State: _____ ZIP:_____

Phone: _____ 501(c)(3) Tax ID Number:_____

Percent of Benefit to be payable to the Qualified Charitable Organization (QCO): _____%

3) Signature of Owner

I understand the beneficiary designation(s) noted here is final unless revoked by a future beneficiary change form.

First Name: _____ Middle: _____ Last: _____

Phone: _____ Email:_____

Signature of Owner: _____ Date: _____

FOR HOME OFFICE USE ONLY

Certificate No.: _____ This request is accepted on MM/DD/YYYY: _____

By: _____

On Behalf of 1891 Financial Life

REMARKS:

ABOUT CHARITABLE GIVING RIDER

Death benefits are payable under the policy to which this rider is attached, the benefit paid will equal to the sum of:

a) A minimum of 1% of the contract's at-issue "Benefit Amount", or its adjusted benefit amount in the event of a subsequent reduction in the at-issue benefit amount after any loan balance is deducted; and will not include any dividend amounts or rider benefits payable. The death benefit payable to the beneficiary(ies) of the contract will be reduced by this amount.
b) 1891 Financial Life will match the amount calculated in (a).
c) The sum of (a) and (b) will not exceed $2,500.

[1]A qualified charitable organization ("QCO") is defined as an organization which is organized and operated exclusively for tax-exempt purposes and meets the requirements set forth under section 501(c)(3) of the Internal Revenue Code and supports the mission and purpose of 1891 Financial Life as described in the Articles of Incorporation. 1891 Financial Life reserves the right to reject any QCO that does not support our mission and purpose[2].

[2]The purposes of the Society are to: promote friendship, unity and true Catholic charity among its members, foster fraternal and benevolent activities, further the progress of the Catholic Church, encourage patriotism and loyalty to the United States of America, and provide death, disability and other benefits, rights and privileges, as authorized by these Articles of Incorporation and Bylaws and in accordance with the laws of Illinois.

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PRODUCER'S REPORT

Provide details in Field Underwriting Remarks, section below.

1) Source of Business:

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

2) Market Type:

☐ Existing customer ☐ Business owner ☐ Social media
☐ Women's markets ☐ Multicultural markets ☐ Families with special needs
☐ Family markets ☐ Alternative markets ☐ 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
_____	_____	_____	_____%
Insurance Producer	Signature Insurance Producer	1891 Financial Life Agent Code	Split

PRODUCER'S UNDERWRITING REMARKS: Did you notice anything while completing the application with the applicant?

1891 financial life

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IMPORTANT NOTICE
REGARDING REPLACEMENT OF INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one—or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:

Use additional sheets, as necessary.

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1) Can there be reduced benefits or increased premiums in later years?
   ☐ No ☐ Yes, explain: _____

2) Are there penalties, set up or surrender charges for the new policy?
   ☐ No ☐ Yes, explain emphasizing any extra cost for early withdrawal:
   _____

3) Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
   ☐ No ☐ Yes, explain: _____

4) Are there adverse tax consequences from the replacement under current tax law?
   ☐ No ☐ Yes, explain: _____

5) Are interest earnings a consideration in this replacement?
   ☐ No ☐ Yes, If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees, and other factors:
   _____
   _____
   _____

6) Are minimum amounts required to be on deposit before excess interest will be paid?
   ☐ No ☐ Yes, explain: _____

7) If the new program is based on a variable or universal life insurance policy or a single premium policy or annuity:
   a. Are the interest rates quoted before, or after, fees and mortality charges have been deducted?
      ☐ No ☐ Yes
   b. Interest rates are guaranteed for how long? _____
   c. The minimum interest rate to be paid is how much? _____
   d. If applicable, the rate you pay to borrow is _____,
      and the limit on the amount that can be borrowed is: _____
   e. The surrender charges are: _____
   f. The death benefit is:_____

8) Are there other short or long term effects from the replacement that might be materially adverse?
☐ No ☐ Yes, explain: _____

_____ _____
SIGNATURE OF INSURANCE PRODUCER PRINTED NAME OF INSURANCE PRODUCER

_____
ADDRESS

_____
DATE

LIST OF POLICIES OR CONTRACTS TO BE REPLACED:

Company	Insured	Contract No.
_____	_____	_____
_____	_____	_____
_____	_____	_____

CAUTION.
The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.
- Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.

_____
Completed Copy Received

_____ _____
Applicant's Signature Date

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

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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