

## Application for Life Insurance

**HOME OFFICE USE ONLY:** Agent # \_\_\_\_\_ Policy # \_\_\_\_\_ Eff. Date \_\_\_\_\_

### PART I - GENERAL INFORMATION

<b>1. Proposed Insured</b> (Please print full name)	Marital Status	Sex	Date of Birth	Age	Height	Weight	Social Security No.
	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> M <input type="checkbox"/> F			Ft. In.	Lbs.	

**2. Resident Address**  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_

**3. Owner** (if other than Proposed Insured)  
 Full Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_ Social Security or Tax I.D. No. \_\_\_\_\_

**4. Benefit/Billing Information**  
 Face Amount: \$ \_\_\_\_\_ Initial Premium: \$ \_\_\_\_\_  
 Premium Mode/Method:  Monthly Bank Draft     Monthly Direct     Quarterly Direct     Semi-Annual Direct     Annual Direct     List Bill  
 Automatic Premium Loan:             Yes                             No

**5. Beneficiary** (Print full name)  
 Primary: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Contingent: \_\_\_\_\_ Relationship: \_\_\_\_\_

### PART II - MEDICAL INFORMATION

**IF ANY PART OF QUESTIONS 6, 7, 8, 9 or 10 IS ANSWERED "YES", COVERAGE WILL NOT BE ISSUED.**

	YES	NO
6. Have you been hospitalized, confined to a nursing facility, currently disabled or been disabled in the past 24 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been treated for or had angina/chest pain, peripheral vascular disorder and/or nervous system disorder, in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been hospitalized for insulin dependent diabetes in the past 3 years? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past 5 years, have you been diagnosed with, treated for or had:		
a) Internal Cancer, Melanoma, Hodgkins Disease or Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>
b) Heart Attack, Heart Surgery, Congestive Heart Failure or Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
c) Kidney Failure or Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
d) Emphysema or Chronic Obstructive Lung Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
e) Alcohol or Drug Addiction .....	<input type="checkbox"/>	<input type="checkbox"/>
f) Alzheimer's Disease or Organ Transplants .....	<input type="checkbox"/>	<input type="checkbox"/>
g) Lou Gerhig's Disease, Down's Syndrome, Muscular Dystrophy, Multiple Sclerosis or Cerebral Palsy .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been diagnosed as having, or been tested positive for, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your weight exceed the limit for your height on the Maximum Body Build Table below? .....	<input type="checkbox"/>	<input type="checkbox"/>

**MAXIMUM BODY BUILD TABLE**

Height	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
<b>Weight Limit (lbs.)</b>	205	215	225	230	235	240	245	250	255	260	265	270	280	285	290	295	305	310

### PART III - MISCELLANEOUS INFORMATION

	YES	NO
12. Do you currently smoke cigarettes or have you smoked in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Will this insurance replace any existing life insurance policy? .....	<input type="checkbox"/>	<input type="checkbox"/>
If YES, Name of Company and Policy No. _____		
14. Has the Proposed Insured had any life insurance application or policy postponed, rated or declined in the past six months? .....	<input type="checkbox"/>	<input type="checkbox"/>
If YES, give reason: _____		

AUTHORIZATION TO MY BANK

If Bank Draft Authorization ATTACH VOIDED CHECK HERE and sign Authorization at right.

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits made to my account and drawn by Provident American Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I hereby agree that if any such debit is not paid by you for any reason, with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such non-payment results in the forfeiture of insurance. This authority is to remain in full force and effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit to my account.

\_\_\_\_ X \_\_\_\_\_
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee \_\_\_\_\_ I hereby authorize \_\_\_\_\_
Name Name of Employer

to deduct from my salary and pay to Provident American Insurance Company, Dallas, Texas, the monthly deposits as set forth below. Beginning with the month of \_\_\_\_\_, in the amount of \$ \_\_\_\_\_ each month.

\_\_\_\_\_
Date Signature of Employee

APPLICANT'S STATEMENT

I have read the completed application. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by the Company during the lifetime of the Proposed Insured. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy Incontestability Provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against any Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MEDICAL AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person, that has any record or knowledge of me or my health, to give Provident American Insurance Company, or its representatives or its reinsurers any such information. I understand that such information will be used to determine my insurability. A copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date signed, and that I may request a copy of it.

The insurance applied for  will  will not replace any existing life insurance or annuity.

\_\_\_\_\_
Signature of Owner (if not Proposed Insured) Signature of Proposed Insured (parent or guardian if under 15)

\_\_\_\_\_
Date Signed at: City State Zip

AGENT'S STATEMENT

To the best of my knowledge the insurance applied for  will  will not replace any existing life insurance or annuity. I certify that any information recorded by me on this application is true and accurate to the best of my knowledge. I further certify that I have personally met with the applicant, and that I have witnessed the signing of this application by the applicant.

\_\_\_\_\_
Agent's Signature Agent No.

\_\_\_\_\_
Date Signed at: City State Zip