wellabe®

Application for Group Life Insurance for Great Western Preneed Plans Trust

Great Western Insurance Company
A Wellabe® Company
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Upon approval of this application, the certificate will be delivered to:
❒ Insured ❒ Owner ❒ Agent ❒ Funeral home

Part A: Proposed insured *(Full legal name)*

First name | M.I. | Last name | Suffix | Date of birth *(MM/DD/YYYY)* | Gender | Age

Address | City | State | ZIP code

Phone number | Email address | Social Security number

Part B: Owner *(Complete only if other than proposed insured)*

First name | M.I. | Last name | Suffix | Date of birth *(MM/DD/YYYY)* | Gender | Age

Address | City | State | ZIP code

Phone number | Email address | Relationship to insured | Social Security number

Part C: Beneficiary *(Full legal name)*

Primary: First name | M.I. | Last name | Suffix | Relationship to insured | Date of birth

Address | City | State | ZIP code | Phone number

Contingent: First name | M.I. | Last name | Suffix | Relationship to insured | Date of birth

Address | City | State | ZIP code | Phone number

Part D: Funeral home

Funeral home full name | Funeral home number | Phone number

Address | City | State | ZIP code

Part E: Requested benefits/certificate information

❒ Single Premium plan — Face amount: $_____ — Premium: $_____

❒ Multi-payment plan — Face amount: $_____ — Premium: $_____

Plan type: ❒ Voyage ❒ Course | ❒ First-day coverage ❒ Guaranteed issue | *Plan length*: ❒ 1 yr ❒ 3 yr ❒ 5 yr ❒ 10 yr

❒ Down Payment rider — Face amount: $_____ — Premium: $_____

The following riders are available with both Single Premium and Multi-payment plans.

❒ Away-from-home rider: One-time **$10 premium**

❒ Grandchild rider: One-time **$10 premium** Complete separate application.

Initial payment

❒ Mobile deposit/Deposit ticket: Check #:_____ Confirmation #:_____
❒ Credit card: Token ID:_____ Confirmation #:_____
❒ Check#:_____
❒ Automatic withdrawal (see payment authorization form)

Total amount submitted for this application: $_____

Ongoing payment mode: ❒ Mo ❒ Qtr ❒ Semi ❒ Ann | ❒ Automatic withdrawal ❒ Credit card ❒ Direct billing

Optional health questions *(only required if selecting a first-day coverage multi-payment plan)*

1. Now or within the last **two** years, has the proposed insured been hospitalized or in a nursing home, or has the proposed insured been advised to be hospitalized or in a nursing home and refused? ❒ Yes ❒ No

Part E: Requested benefits/certificate information (continued)

2. In the last **two** years, has the proposed insured been diagnosed with, treated for, or prescribed medication by a health care provider for any of the following diseases: cancer; tumor; insulin-dependent diabetes; human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS-related complex (ARC); or any disorder of the blood, kidney, lung, brain, heart, circulatory system, or liver? ❒ Yes ❒ No

If either of the questions is answered "Yes" or is not answered, I understand that I will be issued a certificate with up to a two-year Limited Death benefit as provided on the reverse side of this application.

Please provide the name and phone number of your primary care physician (required for first-day coverage):

Primary care physician's name	Phone number

Part F: Irrevocable assignment

I hereby ***irrevocably assign*** and ***transfer*** the death benefits of this certificate to the following funeral home as their interest may appear: _____. I understand fully the effects of this assignment and transfer. I understand that by irrevocably assigning the benefits, I waive my rights to access the cash value after the 30-day right to cancel, including surrendering the certificate for its cash value and obtaining a certificate loan.

Part G: Agreement

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Acknowledgments: By signing below, I, the proposed insured and owner, agree that to the best of my knowledge and belief that statements in this application are complete and true. I certify that all insurable interest laws are met in the state in which the certificate is issued and that no illustration was used in the sale of this product. I agree to notify the insurer if any statement given in the application changes before certificate delivery; any insurance issued will be invalid unless the proposed insured is alive and in the same health as described in this application at time of certificate delivery. Great Western Insurance Company (GWIC) shall not incur liability under the application until it has been received and approved by GWIC, the first full premium for the chosen mode has been received by GWIC, and a certificate has been issued and delivered to the owner. If the application has not been accepted and approved within 30 days of the date thereof, no certificate will be issued, and all premiums will be returned. Further, by keeping the certificate past the free-look period, my written consent is hereby given to any change(s), correction(s), or addition(s) to the certificate for which I am applying.

Authorization (only for multi-pay, first-day coverage certificates): I, the proposed insured, authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan or any other entity that possesses any diagnosis, treatment, prescription or other medical information about me to furnish such health information to GWIC and the entities with which it contracts to administer insurance applications (collectively the "Company") and their agents and representatives for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. A copy of this approval will be as effective as the original. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or its reinsurers to make a brief report of my personal health information to the MIB.

X Proposed insured's signature	Signed in city, state	Date *(MM/DD/YYYY)*

❒ Please check if you are signing as a POA or guardian and provide the proper documentation.

X Owner's signature *(If other than proposed insured)*	Signed in city, state	Date *(MM/DD/YYYY)*

Agent's full name *(please print)*	Agent number
X Agent's signature	Date *(MM/DD/YYYY)*

Use this table to determine the limited death benefit during the first two years of a guaranteed-issue plan. Certificate or policy holders who answer “yes” to any health questions qualify for this type of plan.

Directions: To determine the death benefit, multiply the face amount of the certificate or policy by the percentage in the table which corresponds to the plan type and certificate/policy month in which they die. Round off the result to the next whole dollar.

Policy Month	One Pay	3 Pay	5 Pay	10 Pay
1	9.4%	4.1%	3.3%	2.5%
2	18.8%	8.2%	6.6%	5.0%
3	28.2%	12.3%	9.9%	7.5%
4	37.6%	16.4%	13.2%	10.0%
5	47.0%	20.5%	16.5%	12.5%
6	56.4%	24.6%	19.8%	15.0%
7	65.8%	28.7%	23.1%	17.5%
8	75.2%	32.8%	26.4%	20.0%
9	84.6%	36.9%	29.7%	22.5%
10	94.0%	41.0%	33.0%	25.0%
11	100%	45.1%	36.3%	27.5%
12	100%	50.0%	40.0%	30.0%
13	100%	54.1%	44.1%	33.3%
14	100%	58.2%	48.2%	36.6%
15	100%	62.3%	52.3%	39.9%
16	100%	66.4%	56.4%	43.2%
17	100%	70.5%	60.5%	46.5%
18	100%	74.6%	64.6%	49.8%
19	100%	78.7%	68.7%	53.1%
20	100%	82.8%	72.8%	56.4%
21	100%	86.9%	76.9%	59.7%
22	100%	91.0%	81.0%	63.0%
23	100%	95.1%	85.1%	66.3%
24	100%	100%	90.0%	70.0%
25	100%	100%	100%	100%