GWIC® GREAT WESTERN INSURANCE COMPANY

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Application for Group Life Insurance for Great Western Preneed Plans Trust *Please Print*

State	Date	Agent Name	Agent # —

Proposed Insured

Full Name		
DOB	Age	☐Male ☐Female
SSN	Phone	
Mailing Address		
City	State	Zip
Email		

Proposed Owner *(if other than Proposed Insured)*

Full Name		
Relationship		☐Male ☐Female
SSN	Phone	
Mailing Address		
City	State	Zip
Email		

Designated Beneficiaries *(Do not leave blank)*

Primary Beneficiary	
Full Name	
Relationship	
SSN	DOB
Address	

Contingent Beneficiary	
Full Name	
Relationship	
SSN	DOB
Address	

Certificate Information

Total Face Amount $	Total Paid to Agent $
Base Face Amount $	Modal Premium $
Down Payment Rider	
Face Amount $	Premium Amount $
☐ Away-From-Home Rider:	One-Time Premium $10
☐ Grandchild Rider:	One-Time Premium $10
Payment Mode ☐ Single ☐ 1 yr ☐ 3 yr ☐ 5 yr ☐ 10 yr	☐ Mo ☐ Qtr ☐ Semi ☐ Ann
☐ Automatic Withdrawal ☐ Coupon Sheet	☐ Voyage ☐ Course
Special Instructions	
Initial Payment: ☐ Deposit Ticket ☐ Mobile Deposit	

Multi-Pay Health Questions

1. Now or within the last **two** years, has the Insured been hospitalized or in a nursing home, or has the Insured been advised to be hospitalized or in a nursing home and refused? ☐ Yes ☐ No _____ Initial
2. In the last **two** years, has the Insured been diagnosed with, treated for, or prescribed medication by a healthcare provider for any of the following diseases: Cancer; Tumor; Insulin-Dependent Diabetes; Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Acquired Immune Deficiency Syndrome-Related Complex (ARC); or any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System, or Liver? ☐ Yes ☐ No _____ Initial

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. _____ Initial

Primary Care Physician Information *(Complete only if applying for first-day coverage payment plans)*

Name	Phone	Address

☐ Opt out of electronic notice: I do not want to receive privacy and other notices electronically. (By not marking the box, I agree to electronic delivery to the email address above.)

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%

*Proposed Insured's Full Name*_____

Irrevocable Assignment

_____ Initial	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 policy loan.

Replacements

Insured: Do you have any existing policies or contracts?	☐ Yes ☐ No	Initial: _____	***If question is answered "yes," complete a replacement form.***
Agent: Are there existing policies or contracts?	☐ Yes ☐ No	Initial: _____	

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 civil fines and criminal penalties.

Authorization Agreement for Preauthorized Automatic Bank Withdrawal *(Submit Voided Check)*

Financial Institution Name — Financial Institution City and State

Routing No. — (Nine-digit number on check)

Account No. — ☐ Checking Account ☐ Savings Account

Please indicate a premium withdrawal schedule: *(Select one)*

(Dates specified for monthly payments cannot exceed 45 days from application signature date)

☐ **Initial** premium to be withdrawn immediately

☐ **Both** one-time initial (withdrawn immediately) and subsequent premium withdrawals every ☐Mo ☐Qtr ☐Semi ☐Ann beginning ____/____/____ (choose day 1-28)

☐ Ongoing premium **only.** To be withdrawn every ☐Mo ☐Qtr ☐Semi ☐Ann beginning ____/____/____ (choose day 1-28)

I hereby authorize Great Western Insurance Company (The Company) to initiate debit entries. If necessary, the Company may credit entries on the above named financial institution and account. This authorization is to remain in full force and effective until the Company receives written notice of its termination (minimum of three weeks in advance).

Print Authorized Name _____

Signature _____ Date _____

Agreement

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 Insured is alive and in the same health as described in this Application at time of certificate delivery. The Company shall not incur liability under the Application until it has been received and approved by the Company, the first full premium for the chosen mode has been received by the Company, and a certificate has been issued and delivered to the Owner. If the Application has not been accepted and approved within thirty (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 healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the Insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care, or treatment provided to the Insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for the lesser of twenty-four (24) months from the date signed or the certificate cancellation, termination, or surrender date. This time limit complies with the time limit, if any, permitted by applicable law in the state where the certificate is delivered or issued for delivery. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC.

Signed at _____ (City, State) , _____ (Date) Insured's Signature _____ (Required (Parent / Guardian if Juvenile Insured))

Owner's Signature _____ (Required if Owner is other than Insured) Agent's Signature _____ #_____ (Agent Number)