MEDMUTUAL LIFE®
A Medical Mutual Company

Individual Life Application

MEDMUTUAL LIFE USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NUMBER: _____

Section I: APPLICANT INFORMATION

Last Name	MI	First Name	
Permanent Residence		City	E-mail Address
County	State	Zip Code	Best Contact # ( )	Alternate # ( )

	First Name, MI (and last name, if different)	Social Security Number	Birth Date	Gender
Self				
Spouse				
1				
2				
3				
4				

Section II: LIFE PRODUCTS

Applicant Basic Life Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Applicant Basic AD&D Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Spouse Basic Life Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Spouse Basic AD&D Insurance
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Dependent Life Insurance
☐ $10,000

Do you, the applicant, own an existing life policy or annuity contract? ☐ Yes ☐ No
If you answered "YES" to the above questions, inform the agent who will provide you an "Important Notice: Appendix A, which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract?
☐ Yes ☐ No

It is understood and agreed that this application shall be made part of the policies for which application is made, and it is further understood:

(1) Basic Life and Dependent Life are subject to the approval of MedMutual Life Insurance Company (MedMutual Life), and nothing contained herein shall be binding upon MedMutual Life until this application is approved and accepted at MedMutual Life's home office.

No waiver or change will bind MedMutual Life unless signed by an Executive Officer of MedMutual Life.

WARNING: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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Section II: LIFE PRODUCTS (continued)

If the proposed insured answers "yes" to any of the following questions 1 through 8 in this section, that person is not eligible for life insurance coverage under this application. If the contract holder is not eligible, dependents will not be eligible either.

To the best of your knowledge and belief:

1. Has the proposed insured ever tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
2. Has the proposed insured **ever** (a) been diagnosed with, or (b) been advised by a member of the medical profession to seek treatment for, or (c) consulted with a health care provider regarding:
   - (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Heart Murmur/Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke/mini-stroke, abnormal heart rhythm, or Cerebral or Symptomatic Aneurysm? ☐ Yes ☐ No
   - (b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis? ☐ Yes ☐ No
   - (c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, or any other disease of the central nervous system? ☐ Yes ☐ No
   - (d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C? ☐ Yes ☐ No
   - (e) Diabetes except gestational or with vascular or renal complications? ☐ Yes ☐ No
   - (f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)? ☐ Yes ☐ No
   - (g) Systemic Lupus or Scleroderma? ☐ Yes ☐ No
   - (h) an organ transplant? ☐ Yes ☐ No
3. **In the past 12 months**, has the proposed insured:
   - (a) required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? ☐ Yes ☐ No
   - (b) received, or been advised by a licensed member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, speech therapy, or is the proposed insured currently confined to any hospital or other medical facility? ☐ Yes ☐ No
   - (c) used any of the following: walker, wheelchair, electric scooter, oxygen or catheter? ☐ Yes ☐ No
   - (d) applied for, received, or is the proposed insured currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity? ☐ Yes ☐ No
4. **In the past 12 months**, has the proposed insured:
   - (a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done? ☐ Yes ☐ No
   - (b) consulted a member of the medical profession for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding? ☐ Yes ☐ No
5. **In the next 2 years**, will the proposed insured engage in any hazardous sports or activities such as motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing? ☐ Yes ☐ No
6. **In the past 10 years**, has the proposed insured:
   - (a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a physician, or other health care provider? ☐ Yes ☐ No
   - (b) used unlawful drugs in any form or used prescription drugs other than as prescribed by a physician (including sedatives, or tranquilizers) in any form? ☐ Yes ☐ No
   - (c) been convicted of or incarcerated for a felony? ☐ Yes ☐ No
   - (d) been hospitalized for high blood pressure or any mental or nervous disorder? ☐ Yes ☐ No
7. **In the past 10 years**, has the proposed insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations? ☐ Yes ☐ No
8. Does the proposed insured's weight fall outside of the acceptable weight range of the following height and weight chart? ☐ Yes ☐ No

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Section II: LIFE PRODUCTS (continued)

Height	Acceptable Weight Range	Height	Acceptable Weight Range
4' 5" but less than 4'6"	72 lbs to 154 lbs	5' 9" but less than 5'10"	125 lbs to 249 lbs
4' 6" but less than 4'7"	75 lbs to 156 lbs	5' 10" but less than 5'11"	129 lbs to 257 lbs
4' 7" but less than 4'8"	79 lbs to 159 lbs	5' 11" but less than 6'0"	132 lbs to 265 lbs
4' 8" but less than 4'9"	82 lbs to 161 lbs	6' 0" but less than 6'1"	136 lbs to 272 lbs
4' 9" but less than 4'10"	85 lbs to 167 lbs	6' 1" but less than 6'2"	140 lbs to 280 lbs
4' 10" but less than 4'11"	88 lbs to 173 lbs	6' 2" but less than 6'3"	144 lbs to 288 lbs
4' 11" but less than 5'0"	91 lbs to 180 lbs	6' 3" but less than 6'4"	148 lbs to 296 lbs
5' 0" but less than 5'1"	95 lbs to 186 lbs	6' 4" but less than 6'5"	152 lbs to 305 lbs
5' 1" but less than 5'2"	98 lbs to 193 lbs	6' 5" but less than 6'6"	156 lbs to 313 lbs
5' 2" but less than 5'3"	101 lbs to 199 lbs	6' 6" but less than 6'7"	160 lbs to 321 lbs
5' 3" but less than 5'4"	104 lbs to 206 lbs	6' 7" but less than 6'8"	164 lbs to 330 lbs
5' 4" but less than 5'5"	108 lbs to 213 lbs	6' 8" but less than 6'9"	168 lbs to 339 lbs
5' 5" but less than 5'6"	111 lbs to 220 lbs	6' 9" but less than 6'10"	172 lbs to 347 lbs
5' 6" but less than 5'7"	114 lbs to 227 lbs	6' 10" but less than 6'11"	177 lbs to 356 lbs
5' 7" but less than 5'8"	118 lbs to 235 lbs	6' 11" but less than 7'0"	181 lbs to 365 lbs
5' 8" but less than 5'9"	121 lbs to 242 lbs	7' 0" but less than 7'1"	184 lbs to 369 lbs

If any Medical Eligibility questions (Section IV 1-8) are checked "YES", please note below, who the condition applies to.

QUESTION NUMBER	PATIENT FIRST NAME	DATE OF BIRTH
EXAMPLE: 2a	*Mark*	/ /

Section III: APPLICANT BENEFICIARY DESIGNATION

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

LAST NAME FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary	/ /		%
Primary	/ /		%
Primary	/ /		%
Primary	/ /		%
Contingent	/ /		%
Contingent	/ /		%
Contingent	/ /		%
Contingent	/ /		%

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Spouse Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

LAST NAME FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary	/ /		%
Primary	/ /		%
Primary	/ /		%
Primary	/ /		%
Contingent	/ /		%
Contingent	/ /		%
Contingent	/ /		%
Contingent	/ /		%

Section IV: BILLING INFORMATION

The first premium payment with the receipt of the application is required; coverage will not be active without a completed application and premium payment.

HOW DO YOU WANT TO MAKE YOUR FIRST PAYMENT?

1. ☐ **FINANCIAL INSTITUTION – Complete the Financial Institution Section below.**
2. ☐ **CREDIT CARD – Complete the Credit Card Section below.**
3. ☐ **CHECK** (In case of insufficient funds, a $20 returned item fee will be applied); **must be included with the application.**

☐ **FINANCIAL INSTITUTION**

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize MedMutual Life Insurance Company® to initiate premium payments from my account. The authorization will remain in effect until MedMutual Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the payment arrangement.

Premiums are to be deducted from: Checking ☐ Savings ☐
(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

In case of insufficient funds, a $20 returned item fee will be applied.

Name and branch of bank/financial institution			Account Number	
Address			Account Holder's Name	
City	State	Zip Code	Routing Number	
Account Holder's Signature				Date

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

☐ **CREDIT CARD**

If you wish to be billed through your credit card, please complete the following authorization: ☐ Mastercard ☐ Visa ☐ Discover

Cardholder Name	Card Number
	CSC – The 3 digit code on back of your credit card
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

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Section V: TERMS AND CONDITIONS

I hereby apply to MedMutual Life Insurance Company (MedMutual Life) for the life insurance coverage indicated on this application.

1. I understand that the life insurance benefits for which I am applying are subject to medical eligibility questions and I agree that I, as the Applicant, have answered the medical eligibility questions to the best of my knowledge and belief on behalf of my spouse, and/or dependents. I also understand that if I answered "yes" to any of the medical eligibility questions that I, my spouse and/or dependents are NOT eligible for the life insurance benefits.

2. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that MedMutual Life, in it's sole discretion, may rescind my policy on the basis of any material misrepresentation or fraudulent response to any question in this Application. I further agree that if a policy is issued, it will be issued by MedMutual Life in full reliance and in consideration of the information, answers and statements contained herein.

3. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein.

4. No issuance, waiver, modification or change of policy or any of MedMutual Life rules or amendments shall be binding upon MedMutual Life unless it is in writing and signed by an authorized officer of MedMutual Life, as applicable.

5. I represent that neither I nor my spouse are receiving any form of payment, reimbursement or compensation for this coverage from any employer.

6. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this application or any information MedMutual Life requests, (b) to advise me that I am not obligated to disclose any condition
of which I am aware concerning my health or the health of any dependent included on the application, (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by MedMutual Life or (d) to bind MedMutual Life in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy, (e) to answer any questions in, or insert any information on, this Application on my behalf, or (f) to approve coverage.

7. My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MedMutual Life's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by MedMutual Life's Privacy Office.

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Section V: TERMS AND CONDITIONS (continued)

8. I understand that I have the right to cancel this coverage within 10 days of receipt of my certificate booklet/policy with a full refund of any premium paid.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current life insurance coverage until I receive an approval letter and certificate booklet/policy from MedMutual Life.

Applicant's or Guardian's Signature	Date	Guardian's Social Security Number (if child only policy)	
Spouse's Signature	Date	Dependent's Signature if 18 or older	Date
Dependent's Signature if 18 or older	Date	Dependent's Signature if 18 or older	Date

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).

If you are working with a Broker/Agent, please complete with your Broker/Agent information.

Sold — Account Executive and Code	
Service — Account Executive and Code	

or

Agent of Record	Tax I.D.
Royal Advantage® Broker	Commission Indicator

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