INDIVIDUAL LIFE INSURANCE APPLICATION

EquiTrust Life Insurance Company
7100 Westown Parkway, Suite 200
West Des Moines IA 50266

Policy #_____
(Home Office Use Only)

Producer Name	Full Office Address	Office Phone #	Producer #	%
#1				
#2				

All references to "the Company" shall mean EquiTrust Life Insurance Company of West Des Moines, Iowa, 50266.

SECTION A – PROPOSED INSURED AND BENEFICIARY INFORMATION

Complete Name of Insured (first-middle-last)

Sex	Age	Birth Date	Social Security Number (SSN)	Birth State

Residential Address	City	State	ZIP

Mailing Address (Optional)	City	State	ZIP

Home/Mobile Phone #	Email Address

PRIMARY BENEFICIARY

Share %:	Relationship:

Complete Name (first-middle-last)	SSN/TIN:	Birth Date:
	Phone #:	Email:

Address, City, State, Zip:

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share %:	Relationship:

Complete Name (first-middle-last)	SSN/TIN:	Birth Date:
	Phone #:	Email:

Address, City, State, Zip:

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share %:	Relationship:

Complete Name (first-middle-last)	SSN/TIN:	Birth Date:
	Phone #:	Email:

Address, City, State, Zip:

☐ Check here if you are attaching additional Beneficiary information.
☐ Check here if the trust will be an owner of the Policy, and also complete the Trust Certification Form.

SECTION B – OWNER (IF OTHER THAN PROPOSED INSURED)
(IF LEFT BLANK, OWNER WILL BE THE SAME AS THE INSURED)

Complete Name of Owner (first-middle-last)	Birth Date	Social Security Number	Relationship to Proposed Insured

Home/Mobile Phone #	Email Address

Residential Address	City	State	ZIP

Complete Name of Joint Owner (if any) - (first-middle-last)	Relationship of any Joint Owner to Proposed Insured

SECTION C – INSURANCE PRODUCT APPLIED FOR

Product _____ Premium Amount $ _____

SECTION D– HEALTH

1. What is the proposed insured's height and weight? Height _____ Weight _____

2. Are you currently hospitalized, bedridden, receiving hospice or home health care, confined to a nursing home, assisted living facility, convalescent care or mental facility or have been hospitalized more than twice in the last 24 months? ☐Yes ☐No

3. Within the last 12 months, have you used supplemental oxygen, walker, wheelchair, urinary catheter, had a blood transfusion or had a pacemaker or defibrillator installed? ☐Yes ☐No

4. Have you been tested for HIV for the purpose of obtaining insurance and received positive test results? ☐Yes ☐No

5. Have you ever been medically diagnosed, treated or hospitalized for:
   a. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC)?..... ☐Yes ☐No
   b. Chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure or required dialysis, paralysis of 2 or more extremities or have you been diagnosed with a terminal illness (life expectancy less than 12 months)? ..... ☐Yes ☐No
   c. Alzheimer's disease, dementia, memory loss or impairment, mental incapacity, schizophrenia, bipolar disorder or organic brain syndrome? ..... ☐Yes ☐No
   d. Muscular dystrophy, vasculitis, or hemophilia? ..... ☐Yes ☐No
   e. Pulmonary fibrosis, pulmonary hypertension, cardiomyopathy, or congestive heart failure? ..... ☐Yes ☐No
   f. Lou Gehrig's disease (ALS), Huntington's disease, scleroderma, or organ transplant? ..... ☐Yes ☐No

6. Have you been diagnosed with diabetes prior to age 30 or have you ever been treated by a member of the medical profession for diabetic retinopathy, neuropathy, or nephropathy, or had insulin shock or diabetic coma? ..... ☐Yes ☐No

7. Within the past 3 years, have you been:
   a. Diagnosed with internal cancer or melanoma, leukemia, lymphoma or have you ever had more than one occurrence of cancer or metastasis (excluding basal or squamous cell skin cancer) or are you currently being treated for cancer or reoccurrence of cancer? ..... ☐Yes ☐No
   b. Diagnosed, treated, or taken medications for cirrhosis, liver failure, chronic pancreatitis, or chronic hepatitis? ..... ☐Yes ☐No
   c. Convicted of reckless driving, operating a vehicle while impaired or under the influence of drugs or alcohol (DWI/DUI)? ..... ☐Yes ☐No

8. In the past 24 months, have you been diagnosed with, consulted a physician or been treated for:
   a. Uncontrolled high blood pressure, chest pain or angina, heart attack or failure, irregular heart rhythm, heart surgery, stroke, transient ischemic attack (TIA), abdominal aortic aneurysm, valve repair or replacement or had any procedure to improve the circulation of the heart, brain or extremities? ..... ☐Yes ☐No
   b. Any respiratory disease including chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, respiratory failure or required oxygen equipment to assist in breathing? ..... ☐Yes ☐No
   c. Any neuromuscular disease including Multiple Sclerosis, grand mal seizures, or Parkinson's disease? ..... ☐Yes ☐No
   d. Rheumatoid arthritis, system lupus erythematosus (SLE) or other connective tissue disease requiring joint replacement, or have you had any amputation caused by disease? ..... ☐Yes ☐No

9. Within the past 5 years, have you:
   a. Used illegal drugs, been treated or advised to have treatment for or excessively used alcohol or drugs of abuse (including prescription drugs)? ..... ☐Yes ☐No
   b. Attempted suicide? ..... ☐Yes ☐No
   c. Been diagnosed by a member of the medical profession, treated or hospitalized for chronic pain with daily narcotic use? ..... ☐Yes ☐No
   d. Been convicted of a felony, awaiting trial for a felony or are you currently on probation or parole? ... ☐Yes ☐No

10. In the past 10 years has the proposed insured had 2 or more of the following impairments: Insulin dependent diabetes, heart attack or heart valve replacement, Stroke or Transient Ischemic Attack (TIA), carotid artery disease, Peripheral Vascular Disease (PVD), Peripheral Artery Disease (PAD) or had multiple strokes or Transient Ischemic Attacks (TIA)? ☐Yes ☐No

11. Are you currently receiving assistance or supervision with eating, bathing, dressing, walking, toileting, or getting out of a chair? ☐Yes ☐No

12. In the past 2 years, have you been declined or postponed for life insurance? ☐Yes ☐No

13. Do you have or have you been advised by a member of the medical profession that you have any disease, injury or impairment that would require hospitalization, surgery or other medical procedures or have you had any diagnostic tests that have not been completed or for which results are not yet available (other than HIV/AIDS)? ☐Yes ☐No

SECTION E

1. **Age 70 and over -** Within the past 12 months, have you visited a doctor or other medical professional?	☐Yes ☐No ☐ NA
2. Are you taking or have you been prescribed medication by a member of the medical profession for any impairment that we asked about previously?	☐Yes ☐No
3. Within the last 24 months, have you used any nicotine based products, any form of electronic cigarette (including nicotine free e-cigarettes) or marijuana?	☐Yes ☐No
4. Have you applied for life insurance with any other insurance companies in the last 2 years?	☐Yes ☐No
5. Are you a citizen or permanent resident of the United States?	☐Yes ☐No

Provide details of all "Yes" answers from Section D questions 2-13 and Section E in the area below.

Question #	Explanation	Dates/Duration	Name of Medical Professional

(Attach a separate sheet if more space is needed.)

SECTION F – COMMENTS *(SPECIAL REQUESTS, REMARKS AND CORRECTIONS OR ENDORSEMENTS)*

(Attach a separate sheet if more space is needed.)

SECTION G – EXISTING COVERAGE/REPLACEMENT

1. Does either the Owner or Proposed Insured have any other life insurance policies or annuity contracts? **If "Yes" and required by your state, complete the Replacement Notice.** ☐ Yes ☐ No

2. Is the Policy applied for replacing or likely to replace any existing life insurance or annuity contracts? **If "Yes," complete any required Replacement Notice.** ☐ Yes ☐ No

3. Are values from an existing life insurance policy or annuity being used to pay premiums on the new Policy? **If "Yes" and required by your state, complete the Replacement Notice.** ☐ Yes ☐ No

4. Indicate the source(s) of funds to be used for the purchase of this product (indicate all that apply):
   ☐ Life Insurance policy ☐ Annuity ☐ Stocks/Bonds/Mutual Funds ☐ CD
   ☐ Variable Life Insurance ☐ Variable Annuity ☐ Other _____

SECTION H – ADDITIONAL QUESTIONS

		Details to each "Yes" answer
1. Will the Proposed Owner and/or Beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this Policy is issued?	☐ Yes ☐ No	
2. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this Policy or a beneficial interest in a trust, LLC, or other entity created on the Owner's behalf?	☐ Yes ☐ No	*If "yes", provide details and a copy of the applicable entity's controlling documents.*
3. Is this Policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity?	☐ Yes ☐ No	
4. Has any party to the application such as the Applicant, Proposed Insured, Owner, or any Beneficiary ever sold, transferred or assigned any life insurance to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	☐ Yes ☐ No	

NOTICE: *State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the policy was issued. You should consult with legal advisors if you have any questions about these matters.*

SECTION I – REPRESENTATIONS AND AGREEMENTS

It is understood that EquiTrust has the right to call you for a follow up phone interview and/or require a medical examination. This Application is not complete until any required phone interview and/or medical examination has been performed.

Facsimile or electronic transmission of this signed, original Application and retransmission of any signed facsimile or electronic transmission thereof shall be the same as delivery of an original. Each party agrees that delivery of this Application by facsimile or electronic transmission as provided above shall be evidence of the execution and delivery of the Application by all parties to the same extent that an original signature could be used. The preceding notwithstanding, at the request of EquiTrust, the other party will confirm facsimile or electronically transmitted signatures by signing an original document.

CERTIFICATION: Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out Item 2 above if you have been notified by the IRS that you are currently subject to backup withholding.

By signing this Application, I represent that the statements and answers in all parts of the Application and Supplements thereto are true and complete to the best of my knowledge and belief and it is agreed that:

1. I have read the Application and all statements as they pertain to the Proposed Insured or Owner.
2. The statements and answers in this Application will be relied upon and form the basis of any insurance.
3. If there are any material changes to the answers provided in this application you agree to inform the Company of any changes before issuance of the policy.
4. No agent or any other person, except an officer of the Company, can make or change any insurance policy or bind the Company by making promises regarding any policy. Any change must be in writing and signed by an officer of the Company.
5. In the case of any apparent errors or omissions found by the Company in this Application, the Company is hereby authorized to amend the same by recording the change in the space provided in Section I, Comments.
6. No insurance shall take effect unless and until the following conditions are met: (a) A policy is issued on this application and delivered to and accepted by the Owner; and (b) The first premium due is paid in full while each proposed insured is alive.
7. No change in amount, age at issue, premium class, plan of insurance, or benefits shall be effective without the written consent of the Owner and the Proposed Insured.
8. I have read the Important Notice Regarding Sales to Military Personnel, if applicable.
   Federal law requires that sufficient information to identify the parties to the purchase of a policy be obtained, and failure to provide such information could result in the policy not being issued, being delayed, unprocessed transaction requests, or policy termination.

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.

The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid back up withholding.

_____

Signed at: City and State

_____ _____

Signature of Proposed Insured Date Signature of Owner (if other than a Proposed Insured) Date

_____

Signature of Producer Date

SECTION J – AUTHORIZATION AND ACKNOWLEGEMENT STATEMENT

THIS IS A HIPAA COMPLIANT AUTHORIZATION

EquiTrust or its reinsurers may obtain information about me or my minor children from: any physician, medical professional, hospital, medical care facility, government agency, public records, employer, insurance company or institution, consumer reporting agency, pharmacies, pharmacy benefit managers, Insurance Laboratory, Veterans Administration, MIB, Inc, or any other person or organization that has any record of information about me. The purpose is to determine eligibility for insurance or benefits. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and/or prescription drug information, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources, except MIB, Inc., are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this Authorization at any time by written notice to the Company; (2) revocation of this Authorization will not affect any prior action taken by the Company in reliance upon this Authorization; and (3) failure to sign, or revocation of this Authorization may impair the Company's ability to process applications or evaluate claims and may be a basis for denying this Application or a claim for benefits.

I further understand and acknowledge that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Acquired Immune Deficiency Syndrome (AIDS).

The Company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, those companies to which I have applied or may apply for life or health insurance or benefits, and the Company's affiliates for claims handling, servicing, underwriting, insurance marketing, and other purposes. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. Disclosure may also be made when required or permitted by law. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

I understand that I have the right to see personal information collected about me, and have the right to correct any information which may be wrong. I understand that I may obtain a description of this Company's information practices by requesting one from my agent of the Company at the address provided with my Policy.

This Authorization is valid for 30 months from the date signed. A copy of this Authorization will be valid as the original.

I have received a copy of this Authorization and the Important Notices, and have read the representations on the previous page.

If replacement is occurring, read the following notice: In many cases, the replacement of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement you are considering.

Signature of Proposed Insured _____ Date _____

COPY FOR INSURED'S FILES

IMPORTANT NOTICE – MIB, INC.

Information regarding your insurability will be treated as confidential. EquiTrust Life Insurance Company ("the Company") or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the MIB Inc.'s file, you may contact the MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc.'s information office is:

50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734
Telephone number (866) 692-6901

The Company or its reinsurers may also release information in its file 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.

IMPORTANT – FAIR CREDIT REPORTING ACT

It is understood that the Company or its reinsurers may obtain an investigative consumer report and that information in an investigative consumer report includes information about my character, general reputation, personal characteristics, and/or mode of living, and that such information is obtained through personal interviews with individuals such as neighbors, friends, or associates of mine. I hereby acknowledge and consent to the Company obtaining and utilizing such reports in its decisions to insure me. I understand that I have the right to make a written request to the Company within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of investigation, and that I may obtain a summary of consumer rights upon request.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

EquiTrust Life Insurance Company ("the Company") or its reinsurers may obtain information about me or my minor children from: any physician, medical professional, hospital, medical care facility, government agency, public records, employer, insurance company or institution, consumer reporting agency, pharmacies, pharmacy benefit managers, Insurance Laboratory, Veterans Administration, MIB, Inc, or any other person or organization that has any record of information about me. The purpose is to determine eligibility for insurance or benefits. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and/or prescription drug information, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources, except MIB, Inc., are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this Authorization at any time by written notice to the Company; (2) revocation of this Authorization will not affect any prior action taken by the Company in reliance upon this Authorization; and (3) failure to sign, or revocation of this Authorization may impair the Company's ability to process applications or evaluate claims and may be a basis for denying this application or a claim for benefits.

I further understand and acknowledge that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

The Company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, those companies to which I have applied or may apply for life or health insurance or benefits, and the Company's affiliates for claims handling, servicing, underwriting, insurance marketing, and other purposes. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. Disclosure may also be made when required or permitted by law. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

I understand that I have the right to see personal information collected about me, and have the right to correct any information which may be wrong. I understand that I may obtain a description of this Company's information practices by requesting one from my agent of the Company at the address provided with my Policy.

This Authorization is valid for 30 months from the date signed. A copy of this Authorization will be valid as the original.

FALSE OR FRAUDULENT INFORMATION – COPY FOR INSURED'S FILES

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.

IMPORTANT NOTICE REGARDING SALES TO MILITARY PERSONNEL

Please read the following Disclosure if you are an Active Duty Service Member of the United States Armed Forces.

You should have received a life insurance illustration at the time you completed the application. If you did not, please request one from your agent or call our office at 866-598-3692.

Who is an active duty service member? An active duty service member is a service member engaged in full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

In accordance with applicable law, the following information is provided with respect to the life insurance policy you have applied for with the Company:

- As a member of the United States Armed Forces, you are advised that subsidized life insurance is available to you under the Servicemembers' Group Life Insurance program (also referred to as `SGLI'). This federally-sponsored program provides up to $400,000 of term life insurance at a cost of $.07 per thousand or $28 per month.
- This policy is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the life insurance product being offered;
- No person has received any referral fee or incentive compensation in connection with the offer or sale of the life insurance product, unless such person is a licensed agent of the Company;
- The Policy contains a free look period. You may choose to return the Policy during the free look period. If returned to the Company at the address shown on the cover of the Policy, your Policy becomes void, and we will refund your premiums paid (according to the terms stated in the Policy).

If you have any questions or do not understand this disclosure, please visit with your agent.

PRODUCER CERTIFICATE – EXISTING INSURANCE/REPLACEMENT TRANSACTIONS

To be completed by the agent. I certify that I have asked the person proposed for coverage all of the questions contained in this Application and have accurately recorded on this Application the information supplied by the person proposed for coverage.

1. Did you provide the brochure to the Proposed Insured? ☐ Yes ☐ No
2. Did you advise the Proposed Insured(s) that they may be contacted by the Company or its authorized representative for the completion of a telephone interview? ☐ Yes ☐ No
3. Did you use only insurer-approved sales materials with this Application and leave an original or copy of all sales materials with the Owner? ☐ Yes ☐ No
4. Did you or will you provide a printed copy of electronically presented sales materials to the Owner no later than the date the Policy is delivered? ☐ Yes ☐ No

Send all supporting documents to expedite the application process.

QUESTIONS REGARDING FIELD UNDERWRITING

5. Did you meet with the client and take the application in person? ☐ Yes ☐ No
6. How long have you known the Applicant and Proposed Insured(s)? _____ Related? ☐ Yes ☐ No
7. Were you approached for this insurance? ☐ Yes ☐ No
   If "yes", explain: _____
8. If the Beneficiary is not a relative, explain fully the insurable interest.
   _____
9. Is the applicant legally married? ☐ Yes ☐ No
   If yes, Spouse's name and amount of life insurance in force. _____
10. Purpose of Insurance:
    ☐ Human Life Value (Income Needs) ☐ Tax Deferral ☐ Estate Planning / Wealth Transfer
    Other (explain): _____
11. Did you ask all required questions in the Application and record the answers in the Insured(s) presence exactly as provided by the Proposed Insured? ☐ Yes ☐ No
12. Are you aware of any Proposed Insured(s) health conditions, not otherwise disclosed in the Application that could impact underwriting results? ☐ Yes ☐ No
    If "yes", explain: _____

QUESTIONS REGARDING REPLACEMENT

13. Does either the Owner or Proposed Insured have any other life insurance policies or annuity contracts? ☐ Yes ☐ No
14. Will this plan replace any existing life insurance or annuity? (Using the definition of Replacement adopted by your state.) ☐ Yes ☐ No
15. Are values from an existing life insurance policy or annuity being used to pay premiums on the new policy? ☐ Yes ☐ No

    If questions 14 and 15 are "Yes," explain the reason for the replacement (including any proposed replacement):
    _____
    _____
16. For any replacement, indicate the type of coverage proposed to be replaced:
    ☐ Term Life ☐ Whole Life ☐ Variable Life ☐ Fixed Annuity ☐ Variable Annuity
    ☐ Other – be specific _____
17. I certify that this Application is in accordance with the Company's written statement of the Company's position with respect to the acceptability of replacements.
    If "not", please explain: _____
    _____

    NOTE: For replacements subject to the Model Life Insurance and Annuity Replacement Regulation, copies of any individualized sales material (including illustrations) must be submitted with the Application.

Signature of Producer _____ Date _____