LEADERS LIFE INSURANCE COMPANY
P O Box 35768
Tulsa, OK 74153

DIRECT SALES INDIVIDUAL TERM LIFE INSURANCE APPLICATION

Leaders Life Insurance Company

Proposed Insured Full Name | **Social Security No.**

Address
Street | City | State | Zip

Email Address | **Telephone No.**

Date of Birth | **Current Age** | **Place of Birth** | ☐ Male ☐ Female

US Citizen? ☐ Yes ☐ No | **If No, Provide Green Card/Visa No.** | **Has the proposed insured smoked tobacco, smoked marijuana, vaped, used e-cigarettes, or used smokeless tobacco within the past 12 months?** ☐ Yes ☐ No

Job Title | **Are you actively at work full time?** ☐ Yes ☐ No | **If no, reason**

Do you currently have life insurance with Leaders Life Insurance Company? ☐ Yes ☐ No

Owner Name(If other than Proposed Insured) | **Owner SSN** | **Relationship**

Owner Address | **Telephone No.**
Street | City | State | Zip

LifeTime Plan | **Insurance Amount** | **Premium**

Proposed Insured Only: ☐ **60% Chronic Condition OR** ☐ **30% Critical Illness** | **Premium**

Accidental Death (Double Indemnity) Benefit - Proposed Insured Only - Ages 18 to 60 ☐ Yes ☐ No | **Premium**

Spouse Term Rider ☐ Yes ☐ No | ☐ Male ☐ Female | **Insurance Amount** | **Premium**

Spouse Name | **Has the proposed insured smoked tobacco, smoked marijuana, vaped, used e-cigarettes, or used smokeless tobacco within the past 12 months?** ☐ Yes ☐ No

Spouse DOB | **Age** | **U.S. Resident?** ☐ Yes ☐ No

Is your spouse actively at work full time? ☐ Yes ☐ No | **If no, reason**

Children's Term Rider $10,000 of Coverage ☐ Yes ☐ No | **U.S. Resident?** ☐ Yes ☐ No | **Premium**

All unmarried Dependent children of the Proposed Insured who are age 14 days to the age of 26 (Coverage ends on 26th birthday). The beneficiary of the children's coverage is, in all cases, the Proposed Insured. | **Total Premium**

Name of Child(ren) to be covered (Please Print)	**DOB** (Enter as MMDDYYYY)	**Name of Child(ren) to be covered** (Please Print)	**DOB** (Enter as MMDDYYYY)
(1)		(3)	
(2)		(4)	

Primary Beneficiary Designation (If incomplete, proceeds will be paid according to the policy)

Name (Please Print Full Name) | Relationship | Phone No.

Contingent Beneficiary Designation (If incomplete, proceeds will be paid according to the policy)

Name (Please Print Full Name) | Relationship | Phone No.

*Beneficiary of spouse and/or children's term coverage is the Proposed Insured

Premium Mode: EFT - ☐ Annual ☐ Monthly **Credit Card -** ☐ Annual ☐ Monthly

Automatic Premium Loan - Should premiums not be paid by the end of the grace period. I authorize Leaders Life to apply any cash value available to pay the premium to keep the policy inforce. ☐ Yes ☐ No

Effective Date:		Home Office Use Only:	
First Draft Date:			

I acknowledge that consideration of this application for coverage will be based upon my answers to the following medical questions being answered truthfully and correctly. I further acknowledge that any policy approved based upon a misrepresentation of the Proposed Insured's health history can result in the policy being rescinded as null and void and denial of benefits to beneficiaries. ☐ Yes ☐ No

Underwritng Questions - Contingent Issue

1. During the last 5 years, has the Proposed Insured, Spouse, children been diagnosed by a member of the medical profession with or tested positive for Human Immunodeficiency Virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or for an immune deficiency?	☐ Yes ☐ No
2. During the past 6 months, has the Proposed Insured, Spouse, children been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home due to a disability or paralysis; or been advised by a member of medical profession to have any treatment, surgery, or medical test (excluding routine preventative testing/care) that has not yet been completed or been *hospitalized**?	☐ Yes ☐ No

** Hospitalized is defined as an admission for inpatient care in a hospital (other than for normal pregnancy or childbirth or broken bones as the result of an accident); receipt of care in a hospice facility, intermediate care facility, or long-term care facility; or receipt of the following treatments wherever performed, whether inpatient or outpatient: chemotherapy, radiation therapy, dialysis, or surgery to remove cancer (other than basal cell carcinoma or cancer in situ).*

Underwriting Questions - Simplified Issue

Proposed Insured Height: _____ ft. _____in. Weight: _____ lbs.

Spouse Height: _____ ft. _____in. Weight: _____ lbs.

3. During the last 10 years has the Proposed Insured, Spouse, children been told by a medical professional that they had:

a. Any chronic (ongoing or recurring) disease or disorder of the *Heart, High Blood Pressure, Brain, Nervous System, Blood (excluding AIDS), Lung or Respiratory System (excluding seasonal asthma)? If yes, please provide additional details below.	☐ Yes ☐ No
b. Any chronic (ongoing or recurring) disease or disorder of the Liver, Kidney, Bladder or Digestive Tract, including Ulcer or Intestinal Disease? If yes, please provide additional details below.	☐ Yes ☐ No
c. *Diabetes? If yes, please provide additional details below.	☐ Yes ☐ No
d. Any type of *Cancer; or any Tumor, Growth, or Lesion that is Malignant/Cancerous? If yes, please provide additional details below.	☐ Yes ☐ No
e. Any chronic (ongoing or recurring) *psychiatric or mental health disorder or disease? If yes, please provide additional details below.	☐ Yes ☐ No
4. Has the Proposed Insured, Spouse, children used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming *drugs, except as prescribed by a physician; or received medical treatment or counseling for (excluding support groups for continued sobriety), or been advised by a physician to discontinue the use of *alcohol or prescribed or non-prescribed drugs? If yes, please provide additional details below.	☐ Yes ☐ No
5. During the past 10 years, has the Proposed Insured, Spouse, children been incarcerated, convicted of a felony, or is the proposed insured currently incarcerated or on parole? If yes, please provide additional details below.	☐ Yes ☐ No
6. During the past 10 years, has the Proposed Insured, Spouse, children plead guilty or been convicted *two or more times* of driving while impaired, intoxicated, or under the influence of any drug or alcohol; or is their driver's license currently suspended? If yes, please provide additional details below.	☐ Yes ☐ No

If you answered yes to questi ons 1, 2, 3 a-e, 4, 5, or 6 please provide the name of the Proposed Insured, Spouse, children, question #, diagnosis, date of diagnosis, medication/dosage, current status/problems, and if applicable, drivers license number, date(s), detail(s), type of offense(s), sentence, and probation information. (Add additional signed and dated sheets if necessary)

*Questionnaire Required

Current Life Insurance

Do you currently have life insurance with this company or another company?	☐ Yes ☐ No

Company:		Amount:		Date Issued:		Purpose:	☐ Business ☐ Personal

Is this policy intending to replace or change any life insurance or annuity contract in force with this company or any other company?	☐ Yes (complete applicable replacement form) ☐ No
Are there life insurance applications pending with this company or other companies?	☐ Yes ☐ No

AUTHORIZATION. I AUTHORIZE: (a) any health plan, physician, healthcare professional, medical practitioner, hospital, clinic, laboratory, pharmacy or pharmacy related facility, medical facility, or other healthcare provider that has provided payment, diagnosis, treatment, care or services to me or on my behalf ("My Providers"); and (b) any insurance company, MIB, LLC (MIB), or other organization, institution or person that has records or knowledge of me or my health ("Other Persons"); to disclose my entire medical record, knowledge of my health and any other protected health information concerning me as permitted by law and the Rules of MIB to the Company, its agents, employees, representatives, reinsurers and any medical or pharmaceutical records retrieval service the Company may engage. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (AIDS virus) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information, and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

The use of disclosures authorized by this document is for the purpose of allowing the Company to: (1) underwrite my application for coverage, make risk rating determinations, and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain valid for a time period, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Leaders Life Insurance Company, P.O. Box 35768, Tulsa, OK 74153, Attention: Privacy Officer.

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed by the receiving party (including the reporting of protected health information to MIB) and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application.

I represent that all statements and answers in this application are complete, true, and correctly recorded to the best of my knowledge and belief and that I have the appropriate knowledge to answer the questions for my spouse and children. I understand that the statements and answers in this application are the basis for any policy issued by the Company, and that no information about them will be considered to have been given to the Company unless it is stated in the application and that I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of a policy. The policy with this application will constitute the entire insurance contract. If the proposed insured, spouse, and any children proposed for insurance are deemed insurable at standard rates; the insurance will not take effect until the effective date and the first premium paid. As owner/insured my signature authorizes EFT or credit card payment of premium for myself and my family members. I understand that the Agent accepting this Application does not have Company authorization to accept risk, pass on insurability, or make, void, waive or change any conditions of the application, policy, or receipt.

NOTICE: 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.

I ACKNOWLEDGE receipt of the Notice of Information Practices including Medical Information Bureau Disclosure Notice and Fair Credit Reporting Act Notice.
I ACKNOWLEDGE receipt of the replacement notice (if applicable).
I ACKNOWLEDGE that *if* I am applying for life insurance with accelerated benefits that I have received the Accelerated Benefit Disclosure.
I AUTHORIZE Leaders Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

Signed at (City)		State		Date (mm/dd/yyyy)	

X	X
Signature of Proposed Insured	Signature of Owner (if other than Proposed Insured)

I represent to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further represent that to the best of my knowledge this policy ☐ *will* ☐ *will not* replace or change any existing life insurance or annuity policy now in force.

AGENT #1 (Print Name)		Signature		AGENT #	
AGENT #2 (Print Name)		Signature		AGENT #	

NOTICE OF INFORMATION PRACTICES

MEDICAL INFORMATION BUREAU NOTICE

Information given in your application may be made available to other insurance companies to which you make an application for life or health insurance coverage or to which a claim is submitted.

Information you provide will be treated as confidential. Leaders Life Insurance Company (Company), or its reinsurers may, however, make a brief report to the MIB, LLC (MIB), which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB will supply such company with the information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: MIB, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Leaders Life Insurance Company, or its reinsurers, may also release information in its files 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.

FAIR CREDIT REPORTING ACT NOTICE

This is to inform you that as part of the Company's procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry may include information as to your character, general reputations, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of investigation, if any.

PLEASE DETACH AND HAND TO APPLICANT