Application for Whole Life Insurance
New Era Life Insurance Company

P.O. BOX 4884, HOUSTON, TX 77210-4884 ✶ 281-368-7200 ✶ 1-877-368-4692

Section A General Information (*Please Print*)

Proposed Insured's Name:	❒ Male ❒ Female	Requested Effective Date:	
Daytime Phone:	Social Security #:		
Address:	City:	State:	Zip Code:
Birthdate:	State or Country of Birth:	Height (ft./in):	Weight (lbs.):
Primary Beneficiary:	Relationship:	Address:	
Contingent Beneficiary:	Relationship:	Address:	

Within the past 24 months, have you used tobacco in any form? ..... ❒ Yes ❒ No

Section B Modified Benefit / Guaranteed Issue Section

If applying for the Guaranteed Issue Modified Benefit plan, please skip Section C and the Telephone Interview Information section.

The Guaranteed Issue Modified Benefit Plan is not available for individuals who reside in a long-term-care-facility or have been receiving hospice care.

Section C Standard Level Benefit Qualifying Section

1. Are you currently hospitalized, bedridden, confined to a nursing facility, receiving hospice home health care, or confined to a wheelchair? ..... ❒ Yes ❒ No
2. Have you had an application for life insurance rejected in the past 6 months? ..... ❒ Yes ❒ No
3. Within the past 24 months, have you had, been treated for (including prescription medications), or been advised to receive treatment for: heart attack, aneurysm, angina pectoris, congestive heart failure, stroke, Transient Ischemic Attack (TIA), lung disease or disorder, liver disease or disorder, neuro-muscular disease, Cirrhosis, emphysema or Chronic Obstructive Pulmonary Disease (COPD), or had to use oxygen or had any heart procedure to improve coronary circulation? ..... ❒ Yes ❒ No
4. Within the past 24 months, have you had, or been advised to receive treatment for (including prescription medications):
   a) Aquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ❒ Yes ❒ No
   b) Alcohol and/or drug use or mental incapacity? ..... ❒ Yes ❒ No
   c) Kidney dialysis, kidney disease or disorder, organ transplant or insulin dependent diabetes? ..... ❒ Yes ❒ No
   d) Parkinson's disease, Alzheimer's disease, dementia, Lou Gehrig's disease (ALS), multiple sclerosis, or systemic lupus erythematosus? ..... ❒ Yes ❒ No
5. Within the past 48 months, have you been diagnosed as having, or been treated for (including prescription medications), or advised to receive treatment for internal cancer or Melanoma? ..... ❒ Yes ❒ No
6. Does your weight exceed the maximum weight on the Maximum Weight Table below? ..... ❒ Yes ❒ No

Height	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
Weight (lbs)	200	205	215	220	225	230	235	240	250	255	265	270	280	285	295	305	315	320	335

Name, Address and Phone Number of Personal Physician:

Telephone Interview Information

New Era Life Insurance Company reserves the right to conduct a telephone interview ("Personal History Interview") directly with the Proposed Insured. Please assist us in completing the interview by providing the following information:

Best time to call: _____ ❒ AM ❒ PM ☎ Phone: (_____) _____-_____ ❒ HOME ❒ WORK

Tear Along the Dotted Line

Conditional Receipt

Received from: _____ for Life Insurance.

Payment is: $_____ ❒ Cash ❒ Check

IMPORTANT: No insurance will be effective until your application is approved and the policy is issued. The agent cannot accept risk or waive any of the Company's rights or requirements. This receipt is not valid unless it is signed by an agent of the Company, the Proposed Insured and the Owner.

All premium checks shall be made payable to New Era Life Insurance Company
Do not make checks payable to the agent or leave the payee blank
SIGNATURE REQUIRED ON THE REVERSE SIDE OF CONDITIONAL RECEIPT

Section D Plan and Premium Information

Plan: ❒ **Standard (Immediate Full Death Benefit)** ❒ **Modified (Modified Death Benefit)**

Face Amount: $_____ Premium: $_____

Automatic Premium Loan: ❒ Yes ❒ No

Premium Mode: ***PAC:*** ❒ Monthly - from account indicated below

Direct Bill: ❒ Annual ❒ Semi-Annual

I represent that these statements are true and complete as of the date I signed this application. I agree that this application will be the basis for, and part of, the Policy that is issued; and that coverage will begin on the effective date in the Policy if the first premium has been paid during the Proposed Insured's lifetime and while his/her insurability remains as stated on this application. I understand any material misstatement or omissions may be used as a basis for rescinding my coverage subject to the incontestability provision and legal proceedings. This means all claims will be denied and the Company's liability will be limited to full refund of premium less any claims previously paid.

I have received and read a copy of the Notice Of Disclosure Of Information, which describes how information is obtained and used by New Era Life Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or the Medical Information Bureau, Inc., that has any records or knowledge of me or my health, to give to New Era Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I or my authorized representative may receive a copy of this authorization.

X _____ _____, On _____,20_____

Proposed Insured's Signature — Signed at (City and State)

X _____ _____, _____

Witness (Licensed Resident Agent) — Child's Parent if not Owner — Owner, if other than Proposed Insured

Pre-Authorization (PAC) Check Payment Plan **(Attach voided check or deposit slip)**

Your Name *(as it appears on your bank account)* _____

Account Number _____

Name of Financial Institution (Bank) _____

Address of Financial Institution (Bank) _____

I hereby authorize New Era Life Insurance Company to initiate debit entries to my account indicated above, and I authorize the Financial Institution named above to charge the amount of such entries to my account. I further authorize Company to initiate credits to my account to correct errors, and Institution to deposit any such corrections to my account.

This authority is to remain in full force and effect until I revoke the agreement as hereafter provided. Any revocation is effective only after Company has received written notice from me to terminate this agreement in such time and manner to afford a reasonable opportunity to act upon the notice. I have the right to stop payment of a debit entry by notification to Institution in such time and manner to afford a reasonable opportunity to act prior to charging the account.

X _____ X _____ _____

Signature — Second Signature for Joint Account — Date

Existing Coverage or Replacement

Do you currently have existing life insurance policies with this company? ..... ❑ Yes ❑ No

Is the insurance applied for to replace existing life insurance in this or any other company? ..... ❑ Yes ❑ No

If "Yes", give Company Name(s) and Policy Number(s): _____

X _____ X _____ _____

Signature of Agent — Signature of Applicant — Date

Agent Information

I certify that I have personally asked each question on the application to the applicant and have truly and accurately recorded the answers provided. To the best of my knowledge, replacement of an existing policy ☐ IS ☐ IS NOT involved in this transaction.

Agent _____ Percent _____ License No. _____

Agent _____ Percent _____ License No. _____

Tear Along the Dotted Line

Conditional Receipt

I have received and read this conditional receipt. It has been explained to me by the agent. I understand and agree to all the conditions and limitations.

X _____ _____ _____ _____

Proposed Insured's Signature — Date — Agent — Owner, if other than Proposed Insured

Notice of Disclosure of Information

Information regarding your insurability will be treated as confidential. However, New Era Life Insurance Company or its reinsurers may request information from the Medical Information Bureau (MIB, Inc.) and make a brief report to it. The MIB, Inc. is a non-profit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB company for life or health insurance or a claim is submitted to such a company, the MIB may supply that company with information it has in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it has in its file. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Federal Fair Credit Reporting Act. The address of the MIB information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, Telephone (617) 426-3660. The Company and its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.