Motorists Life

Member of Motorists Insurance Group

SIMPLIFIED ISSUE WHOLE LIFE / GRADED BENEFIT WHOLE LIFE

Application/New Business Packet

In order to expedite the processing of this application, please make sure all required forms are signed and submitted with the initial application.

Required forms:

- ❑ SIWL/GBWL Application for Life Insurance – ICC 10-853-AP (4-12)
- ❑ Applicant Notice/Fraud Statement/Cash Receipt - ML-660 (12-08)
- ❑ HIPAA form (submit one with application; one to be left with applicant) – ML 159 (6-16)
- ❑ Accelerated Benefit Disclosure – ML-635 OH (9-97)

Also Included:

- ❑ Preferred SIWL Supplemental Application – ICC 10-835 (4-10)
- ❑ Child Rider form ICC 10-857 A (4-10)
- ❑ Electronic Funds Transfer (EFT) form ICC 10-73 (4-10)
- ❑ Replacement Form – ML-OH-3 (3-07)
  Required if applicant has existing coverage
- ❑ Point of Sale Interview Guidelines/Prescription Ineligible List ML-271 (3-17)

OHIO

Agent Guidelines for SIWL & GBWL "Point-of-Sale" Interview

Step #1: Complete the application (and HIPAA form) with the proposed insured as you normally would. Based upon their answers, determine which product the proposed insured is qualified for (*Simplified Issue Whole Life or Graded Benefit Whole Life*) and complete the appropriate application accordingly.

Step #2: Before initiating the call to the ESP interviewer,

Make sure you:
Have your eight (8) digit agent producer number available.
Have completed the application with type of plan and insured's personal information.

Make sure the proposed insured has:
Name, address and phone number of their personal physician.
List of all prescription medicine, the dosage and name brand.

Step #3: Call ESP Interviewer at 1-855-699-3048 with proposed insured present.

ESP (Elite Sales Processing) Hours of Operation (Central Time)
Monday – Thursday: 8:00 am to 9:30 pm
Friday 8:00 am to 5:00 pm
Weekend/Holiday: Same procedure, only leave information on voicemail and interviewer will call the next business day.

Step #4: Give your name, producer number and business phone number.

Step #5: Interviewer will direct you to put proposed insured on the line.

Step #6: Upon completion of interview with insured, you will get back on the line for the results.

Step #7: You will be advised:

(1) To submit Simplified Issue Whole Life application; or
(2) To submit Graded Benefit Whole Life application; or
(3) The application will be processed as incomplete with an explanation; or
(4) The application is declined with an explanation.

Prescription Ineligible List for Final Expense*

Brand	Generic	Disorder
Aricept	None	Alzheimer's, Dementia
Atrovent	Spiriva	Emphysema
Bumex	Bumetanide	CHF, Hepatic, Renal
Combivent	None	Emphysema
Coreg	Carvedilol	CHF
Demadex	Torsemide	CHF and Renal
Digitek	Digoxin	CHF
Lanoxicap	Digoxin	CHF
Lanoxin	Digoxin	CHF
Lasix	Furosemide	CHF
Insulin**	Humulin, et al	Diabetes

Your customer will be asked about their weight on the POSI.

"Females weighing over 300 pounds and males weighing over 350 will not be eligible for either the SIWL or the GBWL."

* If the applicant is currently taking or has taken any of these drugs during the past 5 years they will not be eligible for simplified issue whole life or graded benefit whole life

** Exception: Oral is eligible for SIWL/GBWL; Insulin by injection, pump or inhalation eligible for GBWL

Motorists Life
Member of Motorists Insurance Group

H.O. USE

Agency # | Prod # | Split % | Agency # | Prod # | Split %

MOTORISTS LIFE INSURANCE COMPANY • 471 East Broad Street • Columbus, Ohio 43215

Application For Simplified Issue & Graded Whole Life Insurance Policy Or Whole Life Rider

1. First Name | MI | Last Name | (Former) | M F ☐☐ | Date of Birth | Age | Place of Birth | Social Security No.

Street Address | City | County | State | Zip | HT __ WT __ | (Within City Limits) ☐ Yes ☐ No

2. Have you used any form of tobacco in the past 12 months? ☐ Yes ☐ No | Telephone ( )

3. **Face Amount** $ _____

4. ☐ Include Accelerated Benefit Rider (Submit Authorization where required)

5. Premium Amount $ _____ ☐ EFT ☐ Other _____ Draft 1st Premium ☐ (If EFT complete Authorization Form) (If draft 1st premium specify draw date on authorization

6. Automatic Premium Loan requested? ☐ Yes ☐ No

7. Do you have any existing life insurance or annuity? ☐ Yes ☐ No (If yes answer to either question) Will you replace any existing life insurance or annuity? ☐ Yes ☐ No please submit the required state replacement forms if applicable)

8. Primary Beneficiary | Relationship | Social Security No. | Contingent Beneficiary | Relationship | Social Security No.

9. Policy Owner, if not you — Name: | Social Security No.
Phone Number: ( ) — Address: | Relationship

9a. (If Payor is other than owner or insured) Payor Information ( ) — Name: | Social Security No.
Address: | Relationship

ANSWER QUESTION 10 FOR ALL APPLICATIONS

	Yes	No
10.a. Do you need assistance with the normal activities of daily living (ADL) such as eating, bathing, dressing, toileting, taking medications or moving about or are you currently confined to a wheelchair, bedridden, or do you use oxygen or breathing equipment to assist in breathing?	☐	☐
b. Are you currently confined in a hospital or have you been confined to a nursing facility, nursing home or rest home within the past six months?	☐	☐
c. Have you in the past 24 months:		
1. Used any illegal, restricted or controlled substance except as prescribed by a medical professional?	☐	☐
2. Been counseled or treated for alcohol abuse or controlled substance abuse?	☐	☐
3. Been diagnosed with or treated for Alzheimer's disease or dementia?	☐	☐
d. Have you in the past 12 months been advised by a medical professional to have surgery, invasive diagnostic testing, hospital confinement or nursing facility confinement and have not done so?	☐	☐
e. Have you ever had or been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or received a positive result of an HIV test?	☐	☐
f. Have you been told you have a terminal medical condition or end stage disease of any type expected to result in death within the next 24 months?	☐	☐

IF ANY ANSWER TO QUESTION 10 is "YES", THE PROPOSED INSURED IS NOT ELIGIBLE FOR ANY COVERAGE. IF ALL ANSWERS ARE "NO", PLEASE PROCEED TO QUESTION 11, IF APPLYING FOR SIMPLIFIED ISSUE WHOLE LIFE.

11. a. Have you in the past 12 months been hospitalized two or more times?	☐	☐
b. Have you within the past 24 months been treated for, diagnosed with, tested positive for or been told by a medical professional you have:		
1. Any form of cancer (other than basal cell skin cancer), leukemia, emphysema, chronic obstructive pulmonary disease (COPD), Lou Gehrig's Disease (ALS) or chronic kidney (renal) disease failure, or insufficiency to include dialysis?	☐	☐
2. Liver disease or failure (including but not limited to cirrhosis, fibrosis and Hepatitis C)?	☐	☐
3. Heart attack, stroke or transient ischemic attack (TIA), congestive heart failure (CHF), or cardiomyopathy?	☐	☐
4. Diabetes requiring insulin by injection, inhalation or pump?	☐	☐
c. Have you within the past 24 months:		
1. Had surgery for a heart or circulatory disorder?	☐	☐
2. Received an organ transplant?	☐	☐
3. If under age 60 been convicted of a felony, incarcerated, or been subject to probation?	☐	☐

IF ANY ANSWER TO QUESTION 11 is "YES", THE PROPOSED INSURED IS NOT ELIGIBLE FOR THE SIMPLIFIED ISSUE WHOLE LIFE. PLEASE PROCEED TO QUESTION 12 FOR THE GRADED BENEFIT WHOLE LIFE.

ADDITIONAL QUESTIONS AND SIGNATURES REQUIRED ON REVERSE SIDE

12. Have you within the past 12 months been treated for, diagnosed with, tested positive for or been told by a medial professional you have:

	Yes	No
a. Had a stroke or transient ischemic attack (TIA)?	☐	☐
b. Had congestive heart failure (CHF), cardiomyopathy, internal cancer, leukemia, Hodgkin's disease?	☐	☐
c. Had amputation of a body part, or chronic, kidney (renal) disease insufficiency or failure including dialysis?	☐	☐

IF ANY ANSWER TO QUESTION 12 is "YES", THE PROPOSED INSURED IS NOT ELIGIBLE FOR THE GRADED BENEFIT WHOLE LIFE.

13. **Plan of Insurance:**
☐ Accidental Death Rider (Face Amt. Same as Base Policy)
☐ Simplified Issue Whole Life
☐ Simplified Issue WL Rider
☐ Graded Benefit Whole Life

For Graded Benefit Whole Life: The Graded Death Benefit is 35% in Year 1 and 70% in Year 2. Full Face Amount if payable after the first 2 years.

APPLICANT'S STATEMENT: I have read the completed application. The above representations are true to the best of my knowledge and belief. I understand all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I agree the policy shall not be in effect until it has been issued by the Company during my lifetime. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy incontestability Provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met.

AGREEMENTS: All physicians, medical practitioners, hospitals, clinics, sanitariums or other medically-related facilities, insurance companies, MIB, Inc., Employer or other organizations, institutions, or persons are authorized to give Motorists Life Insurance Company or its reinsurers all "Medical and/or Non-Medical" information and any other record of knowledge, including dates, treatments, observations and prognosis for me, my health, my family, and the health of my family. Motorists Life Insurance Company and the Company's underwriters or its reinsurers may make a brief report of my personal health information to MIB. A copy of this authorization will be valid as the original. This authorization is valid within 2 years of its date.

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.

Any insurance approved by the company for issuance as a result of this application shall be considered in force only when a policy is issued by the company and said policy manually received and accepted by the applicant and the first premium paid, during the good health of the proposed insured.

I have paid the sum of $ _____ with this Application, dated at _____
city state

this _____ day of _____ _____ .
Year

X _____
Signature of Owner (if not Proposed Insured)

X _____
Signature of Proposed Insured [parent or guardian if under 18 in the State of Pennsylvania. Under 15 in all other states].

AGENT'S STATEMENT: To the best of my knowledge the insurance applied for ☐ **will** ☐ **will not** replace any existing life insurance or annuity. To the best of my knowledge, there is ☐ is not ☐ any existing life insurance or annuity inforce. (If yes, check state requirements for replacement form submission). I further certify that any information recorded by me on this application is true and accurate to the best of my knowledge.

X _____ | % Split
Agent's Signature

X _____ | % Split
2nd Agt Name

Agent's Name (Print)

( )
Agent's Phone Number

Point of Sale Interview has been Arranged/Completed ☐ Yes ☐ No

MAIL POLICY TO: ☐ Applicant ☐ Agent

Special Remarks: _____

MOTORISTS LIFE INSURANCE COMPANY

THIS INFORMATION MUST BE PROVIDED TO THE APPLICANT

Notification of Investigative Consumer Report

As part of our routine underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with you, your family, friends, neighbors, and associates. Upon written request to the Manager, New Business Department, Motorists Life Insurance Company, 471 East Broad Street, Columbus, OH 43215, further information on the nature and scope of the report will be provided.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. Motorists Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (www.mib.com). If you question the accuracy of information in MIB's file, you may contact 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Motorists Life Insurance Company or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Attending Physician Report Disclosure Notice

As part of our underwriting process, a report may be obtained from your personal physician, hospital or other medical facility. This report may provide information on your medical history including diagnoses, medications, hospitalizations or treatment. This information may have a direct influence on the underwriting decision that we make.

Due to the confidential nature of the information contained in these reports, we are not able to disclose this information directly to you. If you would like details of this information or if you question the accuracy of this information we use in our underwriting process, we would be happy to provide that information to a physician of your choice. Upon receipt of a written request, including the complete name and address of the physician, to the Manager, Life Underwriting, at the above address, further information on the nature and scope of the information from the report will be provided to the named physician.

Motorists Life Insurance Company®

NOTIFICATION OF ANTI-FRAUD LAW TO APPLICANTS APPLYING FOR LIFE INSURANCE

INDIANA - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY - "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

OHIO - "Any person who, with intent to defraud or knowing that he 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."

PENNSYLVANIA - "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

TENNESSEE - "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

VIRGINIA - "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

WEST VIRGINIA - "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 fines and confinement in prison."

CASH RECEIPT

(Give to customer in all cases, but do not complete receipt unless first month's premium is received.)
Motorists Life Insurance Company " 471 E. Broad Street " Columbus, Ohio 43215

Received from_____the _____ of _____ _____ ,
(day) (month) (year)
the sum of $ _____ being the payment of _____ month(s) of premium. The insurance applied for shall not take effect until the effective date of the policy, payment of the first premium and before any change in the applicant's insurability. In the event the application is declined, any payment made by the applicant will be returned.

_____ _____
Agent's signature **Agent's telephone number**

Make checks payable to Motorists Life Insurance Company. Do not make payable to agent or leave payee blank.

MOTORISTS LIFE INSURANCE COMPANY • 471 East Broad Street • Columbus, Ohio 43215

PREFERRED SIMPLIFIED ISSUE WHOLE LIFE SUPPLEMENTAL APPLICATION
MUST ACCOMPANY SIMPLIFIED ISSUE WHOLE LIFE APPLICATION (ICC 10-853-AP)

Name of Proposed Insured _____ Social Security No. _____

		Yes	No
1.	In the past **12** months have you been hospitalized overnight?	☐	☐
2.	Have you used any form of tobacco in the past **36** months?	☐	☐
3.	Within the past **36** months have you been treated or medicated for, diagnosed with, tested positive for or told by a medical professional you have any form of diabetes?	☐	☐
4.	In the past **36** months have you been treated or medicated for, diagnosed with, tested positive for or told by a medical professional you have: any form of cancer (other than basal cell skin cancer), kidney failure or kidney insufficiency, leukemia, liver disease or failure, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD)?	☐	☐

IF ANY ANSWER TO QUESTIONS 1 - 4 IS "**YES**," THE PROPOSED INSURED IS NOT ELIGIBLE FOR THE PREFERRED SIMPLIFIED ISSUE WHOLE LIFE.

5. **Height:** _____ feet _____ inches **Weight:** _____ lbs. **(See chart below)**
(The Proposed Insured must be within the height/weight range to qualify)

Minimum/Maximum Height/Weight Chart

HT	WT	HT	WT	HT	WT	HT	WT
4'8"	86-178	5'3"	102-209	5'10"	120-248	6'5"	157-301
4'9"	88-182	5'4"	104-214	5'11"	127-257	6'6"	161-308
4'10"	91-186	5'5"	107-220	6'0"	131-262	6'7"	165-316
4'11"	93-190	5'6"	110-225	6'1"	141-269	6'8"	169-325
5'0"	95-194	5'7"	113-231	6'2"	145-278	6'9"	173-334
5'1"	98-198	5'8"	115-236	6'3"	148-286	6'10"	178-343
5'2"	100-202	5'9"	118-241	6'4"	152-293	6'11"	182-351

I have read the completed supplemental application. The above representations are true to the best of my knowledge and belief. I understand that all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy incontestability provision. I agree that this supplemental application will become a part of any contract of insurance issued as a result of this application.

Dated: _____ _____
Signature of Proposed Insured

_____ _____
Agent Signature Signature of Owner

Payment Modes:

Mode	*Percent of Annual Premium*
Annual	100.0%
Semi-annual	52.0%
Quarterly	26.0%
Monthly EFT	8.6%

Premiums are guaranteed for the life of the policy.

MOTORISTS LIFE INSURANCE COMPANY
471 E. Broad St., Columbus, Ohio 43215

CHILD RIDER SUPPLEMENTAL APPLICATION
$5,000 PER CHILD BENEFIT FOR CHILDREN OR GRANDCHILDREN OF OWNER

ISSUE AGES 15 DAYS - 17 YEARS INCLUSIVE

Name	Date of Birth	Relationship

Health Statement. To the best of my knowledge, the child/children listed above in the past 24 months have not been diagnosed with, treated for, tested positive for, or been told by a medical professional they have: any form of cancer or leukemia; cystic fibrosis; kidney disease; heart or circulatory disorder; liver disease; diabetes; quadriplegia; multiple sclerosis (MS); seizures; muscular dystrophy; sickle cell anemia; or attempted suicide.

And, to the best of my knowledge the children listed above in the past 24 months have not used any illegal, restricted or controlled substance except as prescribed by a medical professional. And, have not been counseled or treated for alcohol or substance abuse or been convicted of a felony, incarcerated or been subject to probation.

Remarks (please note the child's name and any exceptions to the statement above).

_____

_____

I have read the completed supplemental application. The above representations are true to the best of my knowledge and belief. I understand that all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy incontestability provision. I agree that this supplemental application will become a part of any contract of insurance issued as a result of this application.

Dated: _____ _____ _____
Print Owner Name — Signature of Owner

_____ _____ _____
Agent Number — Print Agent Name — Agent Signature

Motorists Life Insurance Company (MLIC) Request and Authorization for Automatic Check Plan and Electronic Fund Transferring Plan

Please read the information below and on the reverse side and complete the agreement, sign and date the form.

The undersigned Depositor hereby requests and authorizes Motorists Life Insurance Company to draw a check or transfer funds electronically on the account of the undersigned Depositor for the purpose of paying premiums on the policies listed below and on any policies issued on the application listed below. It is understood that the Electronic Fund transferring will not alter any policy provision and that MLIC shall not be required to give notice to any premiums becoming due under this Plan. The privilege of paying premiums under this Plan will be revoked by the Company if any two payments are dishonored in a fifteen-month period. The payment of premiums under this Plan may be discontinued upon 15 days' written notice. If this method of payment is discontinued for any reason, premiums for any policy can be paid by another mode and in accordance with the Payment of Premiums Provision of such policy. If necessary, refunds of initial premium will be refunded by Company check. If any payment is dishonored, whether with or without cause and whether intentionally or inadvertently, MLIC will not reimburse any type of fees assessed by your financial institution.

Authorization

MLIC will draft the checking account designated on this form for subsequent premiums only (unless initial premium payment is authorized by checking the box below) once the policy has been approved for issue, subject to the terms below.

☐ Check here to authorize MLIC to draft my checking account for the initial premium and subsequent premium payments subject to the terms of the life insurance contract.

This agreement authorizes: ☐ A new transfer ☐ A change in existing transfer

Complete policy information for all policies to which this authorization will apply:

Insured Name (please print)	Policy Number	Deduction	Check if New Application
		$	
		$	
		$	
		$	

Request Specific Draft Date for Recurring Payments - Must be within 10 days of effective date
Between the 1st and 28th _____ (include mm/dd)

Print Accountholder Name and Address Below: Bank or Credit Union Information:

Account Holder Name	Bank or Credit Union Name	Account Type: Checking or Savings (must be noted)
Address	Address	
City State Zip	City State Zip	
Phone		

For checking accounts, please send a copy of a voided check. If you cannot provide this, you may write the bank routing number and account number in the appropriate fields. To eliminate processing delays, please write legibly.

Authorization to Honor Deductions Made by Motorists Life Insurance Company, Columbus, Ohio 43215-3861

As a convenience to me, I hereby request and authorize you to pay and charge my account listed below deductions made by and payable to the order of MLIC, of Columbus, Ohio, provided there are sufficient collected funds in said account to pay the same upon presentation. By signing below, I (the bank account owner) understand and accept these terms and conditions outlined in this agreement.

	Routing Number (9 digits)										Account Number														
I:										I:															

_____ _____
Accountholder/Authorized Signature(s) Date

Authorization Agreement

I have read the above information and questions on the reverse side of this form. I authorize MLIC to withdraw funds from my checking or savings account to pay premiums on my MLIC life insurance policy(ies).

X_____
Account Owner Signature (Payor) Date

X_____
Proposed Insured Signature Date

X_____
Agent's Signature Date

X_____
Owner Signature (If other than Proposed Insured) Date

Electronic Funds Transfer
Frequently Asked Questions

What is the EFT payment option?

The EFT plan allows us to automatically deduct your premium payment from your checking or savings account on a designated date each month. In most cases, if the designated draft date falls on a weekend or holiday, the draft will occur on the next business day.

Can I use the same authorization to pay the premiums on multiple policies?

Yes. Please list all policies on the attached form and copy to submit with each MLIC Life application. Each policy's draft is a separate transaction on your account.

What happens if my financial institution does not honor a draft?

If your financial institution does not honor a draft, we will attempt to draft from your account again within 3 business days. If the second draft attempt is not honored by your financial institution, your premium due will be considered unpaid and you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your policy, your insurance coverage may no longer be in effect, or may enter its grace period and then lapse.

What happens if my financial institution charges me fees?

If your draft is not honored by your financial institution, MLIC assumes no responsibility for bank charges or fees assessed. No overdraft fees will be reimbursed by MLIC. To help prevent this, we encourage you to obtain overdraft protection from your bank.

What if I change financial institutions?

Contact us and we will provide you with a new EFT Authorization Form to complete, sign and return to us, along with a voided check. Please notify us at least 15 business days before your next scheduled draft date.

What if I need to cancel the EFT plan?

Send in your request (see address below), and we will cancel your EFT enrollment within 7-10 business days. Please indicate your new premium payment preference. If none is selected, we will begin to bill you quarterly. Or you may call us at 1-888-876-6542 to cancel the EFT plan and set up new premium payment options. You must notify us at least 15 business days before your next scheduled draft date.

Motorists Life Insurance Company®
471 E. Broad Street, Columbus, OH 43215

MOTORISTS LIFE INSURANCE COMPANY
471 East Broad Street, Columbus Ohio 43215

Authorization for Release of Health-Related Information to Motorists Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

_____ ____/____/_____
Name of proposed Insured/Patient (please print) Date of Birth

I, for myself, my heirs, my beneficiaries and my personal representatives, authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (hereinafter referred to as "My Providers") to disclose my entire medical record and any other protected health information concerning me to the Motorists Life Insurance Company (Motorists Life), its agents, employees and representatives. This includes, but is not limited to, information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; the use of alcohol, drugs and tobacco; or, the diagnosis and treatment of mental illness, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected information is to be disclosed under this Authorization so that Motorists Life may: underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have in force or have applied for with Motorists Life.

I understand that my information will be kept confidential and will not be disclosed to other persons or organizations, without this written permission, for the purposes stated herein, except to the extent necessary for Motorists Life and its affiliates, representatives, agencies, reinsurers and others (including, but not limited to those persons, businesses, or professionals providing insurance services) as required for Motorists Life to conduct business. This information may also be used by the representative to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the MIB, Inc., or other persons or organizations performing business, professional, or insurance functions, or as may be otherwise allowed by law.

This authorization shall remain in force for 30 months following the date of my signature below, or the time period allowed by law in the state in which the policy is issued, and shall continue in full force and effect after my death. 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 Motorists Life Insurance Company (at the above address), Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Motorists Life 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 and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, Motorists Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization

_____ ____/____/_____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient/Proposed Insured

When completing this Form: Send original to Motorists Life.
Give copy to the Person who signs this.

MOTORISTS LIFE INSURANCE COMPANY
471 East Broad Street, Columbus Ohio 43215

Authorization for Release of Health-Related Information to Motorists Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

_____ ____/____/_____
Name of proposed Insured/Patient (please print) Date of Birth

I, for myself, my heirs, my beneficiaries and my personal representatives, authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (hereinafter referred to as "My Providers") to disclose my entire medical record and any other protected health information concerning me to the Motorists Life Insurance Company (Motorists Life), its agents, employees and representatives. This includes, but is not limited to, information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; the use of alcohol, drugs and tobacco; or, the diagnosis and treatment of mental illness, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected information is to be disclosed under this Authorization so that Motorists Life may: underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have in force or have applied for with Motorists Life.

I understand that my information will be kept confidential and will not be disclosed to other persons or organizations, without this written permission, for the purposes stated herein, except to the extent necessary for Motorists Life and its affiliates, representatives, agencies, reinsurers and others (including, but not limited to those persons, businesses, or professionals providing insurance services) as required for Motorists Life to conduct business. This information may also be used by the representative to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the MIB, Inc., or other persons or organizations performing business, professional, or insurance functions, or as may be otherwise allowed by law.

This authorization shall remain in force for 30 months following the date of my signature below, or the time period allowed by law in the state in which the policy is issued, and shall continue in full force and effect after my death. 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 Motorists Life Insurance Company (at the above address), Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Motorists Life 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 and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, Motorists Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization

_____ ____/____/_____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient/Proposed Insured

When completing this Form: Send original to Motorists Life.
Give copy to the Person who signs this.

MOTORISTS LIFE INSURANCE COMPANY

471 East Broad Street, Columbus, Ohio 43215

DISCLOSURE FOR ACCELERATED BENEFIT FOR IMMINENT DEATH RIDER

(Proposed) Insured's Name _____

(PLEASE PRINT)

( ) New Application ( ) Existing Motorists Life Policy # _____

The Accelerated Benefit Rider will become part of your Motorists Life Insurance Policy at no extra premium charge to you when we receive your signed Disclosure Acknowledgement at our home office in Columbus, Ohio.

If an insured is told by a doctor that he or she is facing imminent death in 12 months or less, the rider makes part of your policy's death benefit available to you while the insured is alive to help meet the continuing cost of the illness. If there is any indebtedness due to outstanding policy loans, the benefit will be used to repay it before the balance becomes available to you. You may, however, use the balance you receive for any purpose. If an advancement is made on your policy, a lien will be established against the Eligible Death Benefit in the amount of all Accelerated Benefits previously advanced, less any such amounts previously repaid. The lien will accrue interest at a maximum rate of 8 percent in arrears compounded daily. You may voluntarily repay all or any portion of the lien at any time. There will be an Administrative Expense Charge each time this Benefit is exercised.

If you add the Accelerated Benefit Rider to your policy and later accept benefit payments, please consider the following:

- **THERE IS NO PREMIUM CHARGE FOR THIS BENEFIT.**
- **THE MAXIMUM BENEFIT AMOUNT IS THE LESSER OF 55 PERCENT OF THE DEATH BENEFIT OR $100,000.**
- **THIS RIDER WILL TERMINATE UPON PAYMENT OF THE MAXIMUM BENEFIT AMOUNT OR UPON TERMINATION OF THE POLICY.**
- **CASH VALUES (IF ANY), LOAN VALUES (IF ANY), AND THE DEATH BENEFIT WILL BE REDUCED ON A PRO-RATA BASIS IF YOU RECEIVE AN ACCELERATED BENEFIT. PREMIUMS ON A FIXED PREMIUM POLICY WILL BE REDUCED. THE PREMIUMS ON A FLEXIBLE PREMIUM POLICY ARE NOT AFFECTED. YOU SHOULD READ YOUR POLICY AND THE RIDER CAREFULLY AS SOON AS YOU RECEIVE THEM.**
- **UNLIKE CONVENTIONAL LIFE INSURANCE PROCEEDS, ACCELERATED BENEFITS PAYABLE UNDER THIS RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR BEFORE APPLYING FOR BENEFITS.**
- **WE WILL NOT ALLOW BENEFITS UNDER THIS RIDER IF THE INSURED'S TERMINAL ILLNESS RESULTS DIRECTLY OR INDIRECTLY FROM INTENTIONALLY SELF-INFLICTED INJURY.**

It is our opinion that a government agency cannot force you to exercise this rider involuntarily in order to apply for, obtain, or retain a government benefit or entitlement. In addition, we do not believe that creditors, a trustee in backruptcy, or a bankruptcy court can force an involuntary application for benefits under this rider. However, laws and their interpretation change rapidly in these areas.

We recommend that you obtain advice from your tax advisor and/or legal advisor if you have any questions about how this rider may affect your personal situation.

DISCLOSURE ACKNOWLEDGEMENT

I acknowledge that I have read and understand the Accelerated Benefit Rider disclosure information.

Date: _____ _____

Signature of Insured/Proposed Insured

_____

Signature of Other Insured or Spouse (If covered)

_____ _____

Signature of Witness (Licensed Agent if new application) Signature of Owner/Proposed Owner (if different from Insured)

ML-635-OH (9-97)

(One copy - Home Office)
(One copy - Proposed Insured)

MOTORISTS LIFE INSURANCE COMPANY

471 East Broad Street, Columbus, Ohio 43215

DISCLOSURE FOR ACCELERATED BENEFIT FOR IMMINENT DEATH RIDER

(Proposed) Insured's Name _____

(PLEASE PRINT)

( ) New Application ( ) Existing Motorists Life Policy # _____

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Date: _____ _____

Signature of Insured/Proposed Insured

_____

Signature of Other Insured or Spouse (If covered)

_____ _____

Signature of Witness (Licensed Agent if new application) Signature of Owner/Proposed Owner (if different from Insured)

ML-635-OH (9-97)

(One copy - Home Office)
(One copy - Proposed Insured)

MOTORISTS LIFE INSURANCE COMPANY
471 East Broad Street, Columbus, Ohio 43215-3861
(614) 225-8358

OFFICE FORM A

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ____ Yes ___ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ Yes ___ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____ .

I certify that the responses herein are, to the best of my knowledge, accurate:

_____
Applicant's Signature and Printed Name Date

I have complied with the procedures stated by the Ohio Department of Insurance and Motorists Life relating to life and annuity policy placements and financed purchases.

All sales materials I used are Motorists Life approved and a copy of the following was left with my client:
☐ client brochure
☐ illustration
☐ _____ other (please specify)

_____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____
(Applicants must initial only if they do not want the notice read aloud.)

(one copy home office)
(one copy applicant)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older--are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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