RESET

Stonebridge Life Insurance Company

APPLICATION FOR INSURANCE

[ ]

Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499 Home Office: Rutland, VT

PROPOSED INSURED INFORMATION

1. Name *(First, M.I., Last)*		2. Mailing Address (Cannot be a P.O. Box) City, State, Zip		
3. Home Telephone No. ( )	4. Work Telephone No. ( )	5. Birth Date	Age	6. Birth State / Country
7. Height / 8. Weight / 9. Marital Status		10. Sex ☐ Male ☐ Female	11. U.S. Citizen ☐ Yes ☐ No	12. *If no, give immigration status/type of visa:*
13. Occupation & Duties	14. Annual Income Current Year _____ Annual Income Previous Year _____ Net Worth _____		15. Social Security No. or Tax I.D. No.	
			16. Drivers License No./ State	
			17. E-mail Address	

18. Have you used any tobacco or nicotine products within the last 5 years? ☐ Yes ☐ No If yes, list type and when used last

BENEFICIARY AND OWNER DESIGNATION *(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)*

19. Primary	Relationship	Primary	Relationship
Primary	Relationship	20. Contingent	Relationship

OWNER *(Unless otherwise noted, the Owner will be the Insured.)*

21. Name	a. Relationship to Proposed Insured	b. Social Security Number
c. Address	d. Birth Date	e. Phone ( )

POLICY INFORMATION

22. Plan: UL _____ ☐ Level ☐ Increasing	Term _____ Guarantee Period _____	23. Amount of Insurance $	24. Planned Premium $

25. Mode of Payment (for bank draft, complete authorization, and collect initial payment.)

☐ Monthly Bank Draft ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other _____

26. ADDITIONAL BENEFITS and AMOUNTS

☐ Additional Insured Rider (AIR) $_____
☐ Base Insured Rider (BIR) $_____
☐ Children's Benefit Rider $_____
☐ Accidental Death Benefit Rider (ADB) $_____
☐ Other _____ $_____

☐ Guaranteed Insurability Rider (GIR) $_____
☐ Waiver of Premium Benefit Rider (WP)
☐ Waiver of Monthly Deduction
☐ Disability Income Rider (DIR) $_____ / month for _____ years.
☐ Other _____ $_____

27. Name of Proposed Additional Insured(s) including any children applying	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last.
								☐ No ☐ Yes _____
								☐ No ☐ Yes _____
								☐ No ☐ Yes _____
								☐ No ☐ Yes _____

28. LIFE INSURANCE IN FORCE If none check this box ☐

Insured's Name	Company (only need if replacing)	Policy Number (only need if replacing)	Face Amount
			$
			$
			$

29. DISABILITY INCOME - INSURANCE IN FORCE If none check this box ☐ *Complete only if applying for Disability Rider.*

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

30. GENERAL QUESTIONS Complete the following. *For YES answers, give full details in the space provided in Section 52.*

31. Will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No

Have you or any Proposed Additional Insured (including any children applying),

32. Had any health, disability or life insurance pending or contemplated with another company? ☐ Yes ☐ No
33. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? ☐ Yes ☐ No
34. Within the past 5 years,
    a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? (If yes, provide state and drivers license number.) ☐ Yes ☐ No
    b. Been or is now fully or partially disabled? ☐ Yes ☐ No
    c. Been charged with or convicted of any felony or been on probation? ☐ Yes ☐ No
35. Within the past 2 years, (any yes answer to 35a or 35b, complete the Aviation and Avocation Questionnaire)
    a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? ☐ Yes ☐ No
    b. Flown other than as a passenger, or plan to? ☐ Yes ☐ No
    c. Foreign residence or travel contemplated? ☐ Yes ☐ No
36. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ☐ Yes ☐ No
37. Family History: Is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer or melanoma in parents/siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition. ☐ Yes ☐ No
38. Do you or any Proposed Additional Insured exercise regularly?. ☐ Yes ☐ No
39. Do you or any Proposed Additional Insured currently or within the past two years consume six or more alcoholic beverages per week? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ☐ Yes ☐ No
40. Have you or any Proposed Additional Insured had any weight change of 10 or more pounds in the past year? ☐ Yes ☐ No

41. MEDICAL QUESTIONS Each question must be individually asked and answered. *For YES answers, give full details in the space provided in Section 52.*

42. Have you or any Proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated for AIDS, or AIDS Related Complex (ARC) or tested positive for the AIDS virus? ☐ Yes ☐ No

(Questions 43 to 49) Within the past 10 years, have you or any Proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having any disease or disorder of the:

43. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? ☐ Yes ☐ No
44. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? ☐ Yes ☐ No
45. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? ☐ Yes ☐ No
46. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? ☐ Yes ☐ No
47. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? ☐ Yes ☐ No
48. Endrocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? ☐ Yes ☐ No
49. Cancer, tumor, polyps, melanoma or other malignancy? ☐ Yes ☐ No
50. Have you or any Proposed Additional Insured (including any children applying) been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? ☐ Yes ☐ No
51. Are you or any Proposed Additional Insured (including any children applying) currently under the observation of a physician or taking medication? ☐ Yes ☐ No

52. ADDITIONAL INFORMATION *Explain all "yes" answers below. If additional space required, use Supplemental Form SA-ADINFO.*

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations) Medical Facilities & Physicians Names, Addresses, Phone Numbers

53. PERSONAL PHYSICIAN(S) *If additional space required, use Supplemental Form SA-ADINFO.*

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

SECTION 54. ILLUSTRATION CERTIFICATION (Universal Life only) The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) – Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same Proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed owner must have personally received and accepted the policy during the lifetime of all Proposed Insured(s) and while all Proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Stonebridge Life Insurance Company, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Stonebridge Life Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Stonebridge Life Insurance Company to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, (3) Notice of Insurance Information Practices, and (4) Disclosure for Accelerated Terminal Illness Benefit, if required. I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Please make checks payable to Stonebridge Life Insurance Company. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: $ _____ **Best time for a personal history interview:** _____ **a.m./p.m. Okay to contact at work?** ☐ **Yes** ☐ **No**

Dated at _____ (City) _____ (State) this _____ day of _____ (Month), _____ (Year)

Signature of Proposed Insured (if age 15 or over)

Signature of Proposed Owner (if other than Proposed Insured)

Signature of Parent or Legal Guardian (if proposed insured is under 18 and Parent/Guardian has not signed as owner)

Signature of Additional Insured

SECTION 55. TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Proposed Owner _____ **Date** _____

SECTION 56. AGENT INFORMATION & SIGNATURE

Signature of Agent	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address
Split Agent Signature (If Applicable)	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address

- Did you ask all questions on the application in the presence of all proposed insureds, record the answers as given, and witness all signatures? ☐ Yes ☐ No
  If not, please provide details. _____
- Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? ☐ Yes ☐ No
  (If yes, submit the state required forms.)

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of $_____ for the insurance application dated _____, with _____ as the proposed insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)
I certify that I have read and reviewed the conditional receipt and the acknowledgment of the applicant and proposed insured in the application. The terms and conditions of the conditional receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____ _____

City State Date Signature of Agent or Authorized Company Rep

_____ _____

Signature of Proposed Insured Signature of Applicant (if other than Proposed Insured)

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE
REGARDING INVESTIGATIVE REPORT

To Proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To Proposed Insured: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To Proposed Insured: Personal information may be collected from persons other than the individual proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Stonebridge Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

AGENT'S REPORT

How well do you know proposed insured?_____

	Yes	No
Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? *(If "yes", explain in Remarks Section)*	☐	☐
Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?) *(If "yes", explain relationship _____)*	☐	☐
Did you see all of those to be insured on the date the application was written? *(If "no", explain in Remarks Section)*	☐	☐

Rate Class:

- ☐ Preferred Elite
- ☐ Preferred Plus
- ☐ Preferred
- ☐ Non-Tobacco
- ☐ Preferred Tobacco
- ☐ Tobacco

1. Agent's Name	Agent No.	% if Split
2. Agent's Name	Agent No.	% if Split

COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED

What is the relationship of the Owner to the primary insured (please explain)?

_____

What is the relationship of the Payor to the primary insured (please explain)?

_____

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy if the health of the insured has changed.

_____

Signature of Writing Agent

PRE-AUTHORIZED WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request _____ to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This Authorization may be terminated by either party by giving written notice to the other.

INITIAL PAYMENT (MUST CHECK ONE BOX)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

ACCOUNT INFORMATION

TAPE VOIDED CHECK HERE
(Place tape along TOP of check)

If not attaching void check or if withdrawing from Savings Account, complete the following information

_____
Bank Name, Office or Branch

_____
Bank Address | City | State | Zip Code

Check one: ☐ Checking ☐ Savings

_____
Payor Name(s)

_____ _____
Transit Routing Number | Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

Premium to Withdraw	
$ _____	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked) ☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

SIGNATURE

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X_____ **Date:** _____