Application for
Individual Whole Life Insurance

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

Policy administered by Aetna Life Insurance Company and its affiliates

ICC20-ACCFE05982
(052020)

Application for Individual Whole Life Insurance

- *Print clearly and use blue or black ink.*
- *Use section 7 for additional remarks, requests, or explanations.*
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512**.

Section 1. Proposed insured information

Proposed insured's name *(first, M.I., last)*

Phone

Residential address *(must be a physical address)*

Apt/suite number

City | **State** | **Zip**

Mailing address *(if different than residential address)*

Apt/suite number

City | **State** | **Zip**

E-mail | **Social Security Number** | **Birth date*** *(mm/dd/yyyy)*

Place of birth | **Age** | ☐ **Male** ☐ **Female**

Are you a legal resident of the United States? ☐ Yes ☐ No

Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes) ☐ Yes ☐ No

Do you have an existing Medicare Supplement policy with Aetna? ☐ Yes ☐ No

If Yes, what is your policy number?

Section 2. Health questions

For the purposes of these questions "you" means the proposed insured. "Diagnosed", "advised", "tested" and "treatment" mean by a licensed physician or medical practitioner. "Terminal condition" means an illness, disease or disorder which would reasonably be expected to cause death within 12 months.

Part A - If you answer "yes" in part A, you are not eligible. Do not complete or submit this application.

1. Are you currently:

A. confined in or been advised to enter a hospital, nursing home, skilled nursing facility, psychiatric facility, correctional facility? ☐ Yes ☐ No

B. receiving or been advised to receive home health care or hospice care? ☐ Yes ☐ No

2. Do you use a wheelchair or mobility scooter or do you have any physical or mental impairment requiring assistance from anyone with the following activities of daily living: taking medications, bathing, dressing, eating, toileting, getting in or out of bed or chair, or moving about? ☐ Yes ☐ No

3. Within the past year have you:

A. used or been advised to use oxygen equipment to assist with breathing (excluding CPAP for sleep apnea) or had or been advised to have kidney dialysis? ☐ Yes ☐ No

B. been advised to have any medical procedure, surgery or a diagnostic test which has not yet been started, completed, or for which results are not known, excluding tests related to the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

4. Have you ever received, or been advised to receive, an organ or bone marrow transplant or an amputation due to any disease or complications of diabetes? ☐ Yes ☐ No

Section 2. Health questions *continued*

5. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus), AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

6. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:

A. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Huntington's Disease, or sickle cell anemia? ☐ Yes ☐ No

B. Alzheimer's disease, dementia or mental incapacity? ☐ Yes ☐ No

C. congestive heart failure, pulmonary fibrosis, any terminal condition or end-stage disease? ☐ Yes ☐ No

D. cerebral palsy, cystic fibrosis, muscular dystrophy or un-operated heart defects? ☐ Yes ☐ No

7. Within the past 2 years have you been diagnosed with, received or been advised to receive chemotherapy or radiation for any form of cancer (excluding Basal or Squamous cell skin cancer)? ☐ Yes ☐ No

8. Have you ever been diagnosed with more than one occurrence of the same or different type of cancer? ☐ Yes ☐ No

Part B - If any "yes" answers in part B, select ***Modified Plan***.

1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment or medication for:

A. alcohol or drug abuse (prescribed or illegal), or used illegal drugs; or been convicted of or plead guilty to driving under the influence? ☐ Yes ☐ No

B. complications of diabetes such as diabetic coma, insulin shock, retinopathy (eye disorder), nephropathy (kidney disorder), or neuropathy (nerve, circulatory disorder)? ☐ Yes ☐ No

C. kidney or liver disease? ☐ Yes ☐ No

2. Within the past year have you been diagnosed with, received or been advised to receive treatment for:

A. angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? ☐ Yes ☐ No

B. stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? ☐ Yes ☐ No

Part C - If any "yes" answers in part C, select ***Standard Level Plan***.
If all "no" answers in Parts A, B and C select ***Preferred Level Plan***.

1. Within the past 2 years have you been diagnosed with, received or been advised to receive treatment for:

A. angina (chest pain), heart attack, cardiomyopathy, or any type of heart or circulatory procedure or surgery? ☐ Yes ☐ No

B. stroke or transient ischemic attack (TIA/mini-stroke), aneurysm or brain tumor? ☐ Yes ☐ No

2. Have you ever been diagnosed with, received or been advised to receive treatment or medication for:

A. Parkinson's disease, Multiple Sclerosis or Systemic Lupus (SLE)? ☐ Yes ☐ No

B. chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema or any other chronic respiratory condition? ☐ Yes ☐ No

Section 3. Benefits and premium information

Initial amount of insurance applied for
$

Plan requested
☐ Preferred Level Plan ☐ Standard Level Plan ☐ Modified Plan

Riders requested *(not available with Modified Plan)*
☐ Accidental Death Benefit Rider ☐ Accelerated Death Benefits Rider ☐ Children's Term Insurance Rider

Requested effective date* *(mm/dd/yyyy)*
.

Nonforfeiture options**
☐ Automatic premium loan ☐ Paid-up insurance ☐ Extended term insurance

Initial premium

☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

I would like subsequent payment withdrawn on the _____day of the month **OR** the ☐ 2nd ☐ 3rd ☐ 4th Wednesday of the month.

Initial premium amount
$

Payment mode
☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

Initial premium method
☐ EFT *(Electronic Funds Transfer)* ☐ Check or money order

The insurance for which you qualify may have a return of premium death benefit for the first two (2) years. The amount of coverage applied for may be less than the amount approved and not all riders are available on all plans.

☐ Check here if you are willing to accept any plan shown above.

Which do you prefer?

☐ Adjust the face amount to match the premium ☐ Keep the same amount of insurance and adjust the premium

*Unless otherwise requested, the effective date is the application signature date as long as the application is received at the administrative office within 15 days.

**If a nonforfeiture option is not selected, extended term insurance is the default.

Mail policy to: ☐ Applicant ☐ Agent

Payment modes

You have a choice of four payment modes for paying your premium. The Company may charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Section 4. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. Percent share must total 100%.

Primary beneficiary name *(first, M.I., last)*
.

Relationship to insured
.

Phone
.

Share
. %

Address
.

Social Security Number
.

Primary beneficiary name *(first, M.I., last)*
.

Relationship to insured
.

Phone
.

Share
. %

Address
.

Social Security Number
.

Section 4. Beneficiary *continued*

Contingent beneficiary name *(first, M.I., last)* | **Relationship to insured** | **Phone** | **Share** %

Address | **Social Security Number**

Contingent beneficiary name *(first, M.I., last)* | **Relationship to insured** | **Phone** | **Share** %

Address | **Social Security Number**

Section 5. Replacement information

1. Does the proposed insured currently have any life insurance or annuity in force? ☐ Yes ☐ No

2. Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ☐ Yes ☐ No

If the answer to either question is "yes", please provide the information below:

Company name | **Face amount** | **Policy number**

Company mailing address *(to send notice of replacement)*

Section 6. Health history optional comments *(not required)*

Provide any additional information available regarding underwriting questions (diagnosis, dates, durations, medications, dosages).

Section 7. Remarks

Owner name:

Address: **City/State:**

Relationship: **Gender:** **Zipcode:**

Section 8. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by taking your insurance application, collecting your initial premium and, if applicable, delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- commissions when a policy is purchased or renewed
- fees for marketing and administrative services
- educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Section 9. Applicant agreement

This agreement is to acknowledge that I am applying for an insurance policy from Accendo Insurance Company that will be issued based on my answers to the questions on this application and information obtained by the company as described below. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the company's administrative office, and made a part of the contract of insurance. An officer of the company is the only one who can make, modify or discharge contracts or waive any of the company's rights or requirements. Any modifications must be documented in writing.

I also understand that, unless otherwise specified in the Conditional Receipt, I do not have coverage until this application is approved, the first full modal premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the company and coverage has become effective.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand and agree that information regarding my insurability will be treated as confidential. Accendo Insurance Company or its reinsurers may, however, make a brief report of my protected health information to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. I understand and agree that if I 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 in its file.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. I may contact MIB at 866-692-6901. If I question the accuracy of information in MIB's file, I 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, MA 02184- 8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, consumer reporting agency, pharmacy, pharmacy benefit manager, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Accendo Insurance Company, or its reinsurers, any such information.

A photographic copy of this authorization shall be as valid as the original.

Applicant signature	**Date signed**
X	.
Owner signature* *(if not proposed insured)*	**Date signed**
X	.
Owner Social Security Number	**Signed in** *(city and state)*
.	.

*If owner or payor is different than proposed insured, indicate name, address and relationship to proposed insured in Remarks (section 7).

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.

Section 10. Bank account information

Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment.
Include a voided check with the application.

Account owner name *(if different than proposed insured's)*

Account owner relationship to proposed insured

☐ Family member; please specify: .....

☐ Living trust ☐ Employer ☐ Power of Attorney ☐ Conservator/guardian ☐ Business owned by proposed insured

Financial institution name

Account type

☐ Checking ☐ Savings

Routing number

☐☐☐☐☐☐☐☐☐

Account number

☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Account owner signature

X

Date signed

Section 12. Agent information

I certify that:

1. The insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

Does the proposed insured have any existing life insurance or annuity contracts? ☐ Yes ☐ No

Will the policy applied for be a replacement or change existing life insurance or an annuity? ☐ Yes ☐ No

If the answer to either question is "yes", have you complied with the requirements of the company and your state regarding this replacement? ☐ Yes ☐ No

All information must be completed. The writing number reflects where commissions will be paid.

Agent name *(printed)*

.

Writing number *(agent or company)*

.

Agent signature

X

Phone

.

Email

.

Section 13. Agent request to split commissions

If this application results in an issued policy through Accendo Insurance Company (ACC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACC commission schedule.

Writing agent name *(printed)*

.

Percentage

. %

Writing agent signature

X

Secondary agent

.

Writing number

.

Percentage

. %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Application for Individual Children's Term Insurance Rider

from Accendo Insurance Company part of the CVS Health® family of companies and Aetna affiliate

- Print clearly using blue or black ink.
- Mail application and check in the provided business reply envelope to **P.O. Box 14399, Lexington, KY 40512**.
- Coverage amount selected will be the same for all covered children.
- You can apply for coverage on a maximum of 9 children as defined below. Attach a second application to list more than 5 proposed insured children.
- Coverage amount may not exceed the face amount of the base policy.

Primary Insured's name | **Policy number** *(if known)* | **Amount of coverage per child**

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

1. Children proposed for insurance

Name natural born children, stepchildren, legally adopted children, grandchildren, legally adopted grandchildren, great grandchildren, proposed for insurance. Insurance will not be provided for newborns less than 30 days of age, children greater than 17 years of age, or children that are not US citizens.

Proposed Insured's name | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen**

☐ Yes ☐ No

Proposed Insured's name | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen**

☐ Yes ☐ No

Proposed Insured's name | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen**

☐ Yes ☐ No

Proposed Insured's name | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen**

☐ Yes ☐ No

Proposed Insured's name | **Social Security Number** | **Birth date** | **Age last birthday** | **U.S. citizen**

☐ Yes ☐ No

2. Beneficiary

If a trust, give Trustee name, Trust name and Trust date. If no beneficiary is named for any child, the beneficiary designation defaults to the Insured of the base policy. Attach a separate sheet if necessary.

Primary beneficiary name *(first, M.I., last)* | **Phone** | **Share** %

Address | **Social Security Number**

Primary beneficiary name *(first, M.I., last)* | **Phone** | **Share** %

Address | **Social Security Number**

Percent share must total 100%.

Contingent beneficiary name *(first, M.I., last)* | **Phone** | **Share** %

Address | **Social Security Number**

Contingent beneficiary name *(first, M.I., last)* | **Phone** | **Share** %

Address | **Social Security Number**

CVS Health®

3. Health history

If any of these questions are answered "yes" that child will be excluded from coverage.

1. Is any Proposed Insured child currently institutionalized or in a care facility? ☐ Yes ☐ No

2. Has any Proposed Insured child ever been diagnosed or been treated by a member of the medical profession for: cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs, or been recommended for an organ transplant? ☐ Yes ☐ No

3. Has any Proposed Insured child ever been diagnosed by a member of the medical profession or tested positive for an Immune Deficiency Disorder, Human Immunodeficiency Virus (AIDS virus), AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

4. Has any Proposed Insured child ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines,or other similar drugs except as prescribed by a physician? ☐ Yes ☐ No

List the children for which "yes" answers were given.

4. Acknowledgement

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application.

Primary Insured signature	**City and state where signed**	**Date**
X	.	.

Agent signature	**Writing number**	**Date**
X	.	.

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.