APPLICATION FOR INDIVIDUAL LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222

www.gpmlife.com

For Ages 50 through 85, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1. Name of Proposed Insured (First, M.I., Last)

2. Gender ❑ Male ❑ Female 3. Date of Birth 4. Place of Birth

5. Proposed Insured's Occupation

6. US Citizen ❑ Yes ❑ No 7. Social Security # 8. Height 9 Weight

10. Home Address of Proposed Insured City State/Country Zip

Primary Telephone Number: E-mail:

Best time to call _____ A.M. _____ P.M. Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

11. Policy: WHOLE LIFE POLICIES

SECURE-Mark LEVEL DEATH BENEFIT	☐ SECURE-Mark	☐ SECURE-Mark
☐ LIFETIME PAY ☐ 10 PAY ☐ 20 PAY	GRADED DEATH BENEFIT	MODIFIED DEATH BENEFIT
☐ Accidental Death Benefit	30% 1st Year, 70% 2nd Year	First 2 Years: Return of Premium + 10% interest
☐ $5,000 Child Insurance Rider (Part 2 Required)	Lifetime Pay	Lifetime Pay

12. Amount Applied for:$ 13. Premium Amount: $

14. Premium Mode: Direct Bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly
Automatic Draft/EFT: ❑ Monthly

15. Automatic Premium Loan (if available) ❑ Yes ❑ No

16. Beneficiary(ies) Name (First M.I., Last) Address (City, State/Country, Zip) Date of Birth Social Security # Relationship

Primary (Class 1) _____

Contingent (Class 2)

*All beneficiaries in a class shall share equally, or to the survivor. Proceeds pass to Class 2 beneficiaries only if no one in Class 1 survives.

17. Owner/Applicant, if other than the Proposed Insured: Name _____

Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address:

18. Physicians' names, addresses and phone numbers: _____

19. a. Life insurance policy or annuity contract in force on All Proposed Insureds: ❑ None ❑ Listed below

Insured	Issue Year	Company	Face Amount	ADB Amount

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? . . . . . ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form including any nicotine product in the past 12 months? . . . . . ❑ Yes ❑ No

If any question from 21 through 27 is answered "Yes", do not complete or submit. If any question from 28 through 30 is answered "Yes", the Proposed Insured may be eligible for SECURE-Mark Modified (Modified Benefit Whole Life): Full Death benefit for accidental death; return of premiums for non-accidental death during the first two years. If any question from 31 through 35 is answered "Yes", the Proposed Insured may be eligible for SECURE-Mark Graded (Graded Death Benefit): Full death benefit for accidental death; limited death benefit for non-accidental death during the first two years and full death benefit thereafter. If questions 21 through 35 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark Level (Whole Life, Full Death Benefit).

	YES	NO
21. Has the Proposed Insured been told by a physician that s(he) has less than 12 months to live?	❑	❑
22. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care or kidney dialysis?	❑	❑
23. Has the Proposed Insured been diagnosed by a physician as having Alzheimer's Disease, dementia, Amyotrophic Lateral Sclerosis (ALS) or been prescribed any of the following medications: [Donepezil (Aricept), Memantine (Namenda), Rivastigmine (Exelon), Galantamine (Razadyne), Tacrine (Cognex)]?	❑	❑
24. Has the Proposed Insured ever been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
25. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure (CHF) or cardiomyopathy?	❑	❑
26. During the past 5 years, has the Proposed Insured been convicted of a felony or misdemeanor, or been on parole or probation for any offense?	❑	❑
27. Is the Proposed Insured currently diagnosed by a medical professional as having or being treated by a medical professional for melanoma, internal cancer, leukemia, or Hodgkin's disease?	❑	❑

	YES	NO
28. During the past 4 years, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for Melanoma, internal cancer, leukemia, or Hodgkin's disease?	❑	❑
29. Is the Proposed Insured currently receiving or has (s)he been recommended to receive oxygen?	❑	❑
30. Does the Proposed Insured need any assistance performing Activities of Daily Living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	❑	❑

	YES	NO
31. During the past 12 months, has the Proposed Insured:		
a. Been admitted to or confined in a hospital two or more times?	❑	❑
b. Been told by a medical professional that (s) he needs a medical procedure, diagnostic test (excluding tests related to the Human Immunodeficiency Virus (AIDS Virus)), surgery, hospitalization or nursing facility care that has not been completed?	❑	❑
c. Been confined to a nursing facility or received home health care?	❑	❑
32. During the past 24 months, has the Proposed Insured been treated by, diagnosed by or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Stroke, Transient Ischemic Attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
b. Organ transplant, or recommendation to have an organ transplant?	❑	❑
c. Parkinson's Disease, seizure, neurological disorder, major depression, schizophrenia, psychosis, Bipolar Disorder, or other psychiatric disorder?	❑	❑
d. Liver disease, kidney disease, pancreatic disease, kidney failure or lupus (SLE)?	❑	❑
e. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
f. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
g. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
33. During the past 24 months, has the Proposed Insured used any illegal drug or been treated by or given medical advice by a medical professional, including office visits, medications or surgery for alcohol and/or drug abuse?	❑	❑
34. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?	❑	❑

35. Has the applicant, Proposed Insured, Proposed Owner or Proposed Beneficiary:

a. entered into, or planned to enter into, any agreement to sell any interest in
   i) the policy applied for, or
   ii) any other life insurance policy? ..... ❑ YES ❑ NO

b. received, or been promised any inducement, fee, compensation, or loan as an incentive to
   i) the policy applied for, or
   ii) any other life insurance policy? ..... ❑ YES ❑ NO

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance or annuity policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

36. If the policy I have applied for is not issued, please issue the SECURE-Mark policy I qualify for, if any, with:

❑ The same premium with a lower face amount. ❑ The same face amount with a higher premium.

I Understand that Accidental Death Benefit Rider and Child Insurance Rider are only available with the SECURE-Mark Level Policy.

(Proposed insured's initials required: _____)

Details to any "Yes" answers: Indicate question number, condition, treatment, diagnosis date.	
For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written to the best of my knowledge and belief. I understand that any misrepresentation, inaccuracy, or incompleteness in an answer to any question about health condition, physical condition, or other question relating to insurability, which is material to any risk assumed, may cause any policy issued to become void during the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.
B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.
C. Any policy issued by GPM Life, or applied for, or elected under section 36, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.
D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy and/or an electronic copy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement 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.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____ (REQUIRED)

To the best of your knowledge:	Yes	No
A. Does any Proposed Insured have any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X _____ _____ _____/_____ _____ _____%
Writing Agent's Signature | Date | State / License # | GPM Life Agent #

_____ Split Agent GPM Life # _____ _____%
Writing Agent's Name (Please Print)

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. **The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.**

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

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To Government Personnel Mutual Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

_____ Date of Birth _____
Name of proposed insured/patient (please print)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, pharmacy records, and any other protected health information concerning me to the Government Personnel Mutual Life Insurance Company (GPM Life) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that GPM Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with GPM Life.

This authorization shall remain in force for 30 months following the date of my signature below. 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 GPM Life at 2211 N. E. Loop 410, San Antonio, Texas 78217, 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 GPM 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 My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, GPM 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

See Reverse Side for Common Questions About this Authorization

Common Questions and Answers about Release of Protected Health Information to a Life or Disability Income Insurer

1. **What is HIPAA?**

   HIPAA is the Health Insurance Portability and Accountability Act of 1996. Its Privacy Rules require, in part, that health care providers receive a signed, written authorization meeting HIPAA's requirements before releasing to others Protected Health Information pertaining to the signer.

2. **May I release complete personal medical information to a life or disability income insurance company?**

   Yes. As you did before the HIPAA Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

3. **Does the minimum amount necessary rule apply to this release to a life or disability income insurer?**

   No. The minimum necessary rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by HHS in a Q&A published December 4, 2002. This information may be found at www.hhs.gov/ocr/hipaa.

4. **Can an insurer request disclosure of a person's "entire" medical record?**

   Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

5. **Does HIPAA mandate the use of one specified form of authorization by everyone?**

   No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The attached signed authorization contains all of the elements required by HIPAA.

6. **What should I do if I have previously agreed to a restriction and now receive an authorization to release the "entire medical record." Does the attached authorization cover PHI that was restricted?**

   You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of the enclosed authorization specifically releases any restricted information.

AUTHORIZATION TO HONOR WITHDRAWALS REQUESTED BY GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

P.O. Box 659567, San Antonio, Texas 78265-9567
(210) 357-2222 Fax (888) 701-3869 (800) 929-4765

– – DEPOSITOR MUST COMPLETE ALL INFORMATION – –

Premium Payor _____
(Print name as shown on bank records.)

Bank/Branch _____ ❑ Checking ❑ Savings

Bank Mailing Address _____
(COMPLETE ADDRESS AND ZIP CODE OF BANK OR BRANCH WHERE ACCOUNT IS MAINTAINED.)

As a convenience to me, I hereby request and authorize you to pay and charge to my account withdrawals requested by GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such requests.

I agree that your treatment of each such request, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such request be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

The GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY is instructed to forward this authorization to you, as required.

_____ _____
Date Signature of Depositor as shown on Bank Records for account to which this Authorization applies.

Please sign and return with a voided check or deposit slip for bank information.

For new policies only, choose from these policy dates:

❑ 1st of month; ❑ 2nd; ❑ 3rd; ❑ 4th; ❑ 5th; ❑ 10th; ❑ 15th; ❑ 20th; ❑ 25th.

Existing policies will be drafted on due dates. Policy number: _____

INDEMNIFICATION AGREEMENT

TO: BANK NAMED ABOVE

In consideration of your compliance with the request of the Government Personnel Mutual Life Insurance Company, hereinafter called the Insurance Company, and the depositor on whose account withdrawals will be made, the Insurance Company agrees, subject to the limitation in paragraph (5):

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored, whether with or without cause and whether intentionally or inadvertently, to indemnify you and hold you harmless for any loss even though dishonor results in a forfeiture of insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

(4) Your participation in this plan may be terminated by 30 days written notice to the Insurance Company and the premium payor.

(5) In the case of EFT (electronic funds transfer) or ACH (automated clearing house) methods of collecting premiums, the above shall be modified to provide the named bank no more indemnification than is required by The National Automated Clearing House rules and any applicable local Automated Clearing House rules.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY


PRESIDENT


SECRETARY

Authorized in a resolution adopted by the Board of Directors of the Government Personnel Mutual Life Insurance Company on October 2, 1991.