Tier One Insurance Company

Home Office: 1932 Wynnton Road, Columbus, GA 31999
Administrative Office: 1021 Reams Fleming Blvd, Franklin, TN, 37064
Telephone Number: 833-504-0336 Website: www.Aflac.com

Application for Individual Whole Life Insurance

Policy **Policy Number:**

Applicant's Information:

Name:_____

Address:_____

Date Of Birth (mm/dd/yyyy):_____

Social Security Number:_____

Gender:_____

Telephone Number:_____

Email:_____

Legal resident of the United States (Y/N):_____

Tobacco Use in the Last 12 months (Y/N) – includes vaping and e-cigarettes):_____

Owner's Information (if other than Applicant):

Name:_____

Address:_____

Date Of Birth (mm/dd/yyyy):_____

Gender:_____

Telephone Number:_____

Email:_____

Legal resident of the United States (Y/N):_____

Relationship to Applicant:_____

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 have 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 require long term use of 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 diagnostic test (other than for routine screening purposes such as vision and hearing exams) which has not 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

5. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV), 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 (excluding Basal or Squamous cell skin 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 or pled 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 Part 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

Benefits and Premium Information

Initial amount of insurance applied for: Plan Requested (Check One)

$_____ ❑ Preferred Level Plan ❑ Standard Level Plan ❑ Modified Plan

Riders Requested (not available with Modified Plan)

❑ Accidental Death Benefit Rider ❑ Accelerated Death Benefit Rider ❑ Children's Term Insurance Rider

Requested Effective Date* (mm/dd/yyyy):_____

Nonforfeiture Options (If a nonforfeiture option is not selected, extended term insurance is the default.)

❑ 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

If the person or entity paying premiums can be someone other than the Applicant or Owner, please provide the information below:

Name of Payor:_____

Address:_____

Date Of Birth (mm/dd/yyyy):_____

Gender:_____

Telephone Number:_____

Email:_____

State of Birth:_____

Driver's License Number:_____

Driver's License Issue State:_____

Legal resident of the United States (Y/N):_____

Relationship to Applicant:_____

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.

Mail policy to: ❑ Applicant ❑ Agent

Payment modes

You have a choice of four payment modes for paying your premium. Tier One 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.

Beneficiary

If no Beneficiary survives the Proposed Insured, we will pay the proceeds to the Proposed Insured's surviving spouse, if any, otherwise proceeds will be paid to the Proposed Insured's estate.

We do not recommend that you name a minor child as your beneficiary. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until Tier One receives legal documentation identifying the person with authority to receive the benefits on behalf of such beneficiary or such beneficiary reaches the age of majority as defined by applicable state law. We suggest you obtain legal advice before naming a minor child as your beneficiary.

If you reside in a community property state, are married, and designate a person other than your spouse as the primary beneficiary, your spouse may have rights to the death benefit of this policy under state law even if you choose not to name them as your beneficiary. We recommend submitting documentation signed by your spouse consenting to your beneficiary designation and waiving any right to proceeds payable under the policy. If you are unsure whether these laws apply to you, consult with your legal or tax advisor to determine whether submission of such documentation is necessary. Unless Tier One has been notified of a community or marital property interest in this policy, Tier One will presume that no such interest exists and disclaims any responsibility for determining the applicability of community property laws or the validity of the beneficiary designation. However, if your spouse claims a community property interest in the proceeds, it may delay the payment of proceeds under the policy. By signing this application, you agree to indemnify and hold Tier One harmless from the consequences of making the designation requested in this application.

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:_____

Share%:_____

Phone:_____

Address:_____

Social Security Number:_____

Primary beneficiary name (first, M.I., last):_____

Relationship to Insured:_____

Share%:_____

Phone:_____

Address:_____

Social Security Number:_____

Contingent beneficiary name (first, M.I., last):_____

Relationship to Insured:_____

Share%:_____

Phone:_____

Address:_____

Social Security Number:_____

Contingent beneficiary name (first, M.I., last):_____

Relationship to Insured:_____

Share%:_____

Phone:_____

Address:_____

Social Security Number:_____

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 any existing life insurance or 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):_____

_____

Health history optional comments (not required)
Provide any additional information available regarding underwriting questions (diagnosis, dates, durations, medications, dosages).

_____

_____

_____

_____

_____

_____

Remarks

Applicant's Statements and Agreements

By signing this application, I understand and agree that:

- The policy applied for will be effective as of the date selected by the Applicant provided the application is approved by Tier One and Tier One has received the first premium.
- I received the Consent Statement for Electronic Transactions, Records, and Signatures, Replacement Notice, and Customer Privacy Policy.
- The contract of insurance is the policy, application, endorsements, and any attached papers.
- No statements made by me or a Tier One representative can change the terms of the contract unless written herein or attached to the policy and approved by Tier One's President and Secretary.
- I have reviewed this application. All answers are complete and true to the best of my knowledge and belief. Any statements are deemed representations and not warranties, and any false statement, material misrepresentation, or omission of any information may result in loss of coverage under the policy.

Authorization: I understand and agree that information regarding my insurability will be treated as confidential. Tier One 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 Tier One, or its reinsurers, any such information.

This authorization will expire 24 months from the date on this form or sooner if prescribed by applicable law in the state where the policy is delivered or issued for delivery. I may revoke this authorization at any time.

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

☐ By checking this box, I agree to the Applicant's Statements and Agreements.

☐ By checking this box, I agree that I have reviewed the benefits and premium of the insurance policy and/or rider(s) that I am applying for and agree to the following:

- I understand the impact that the premium for this coverage has on my income;
- I understand the impact that the total Tier One premium for this coverage and any other Tier One coverage has on my income and believe it to be appropriate for me; and
- I have considered all of my existing life and health insurance coverage, with Tier one and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Tier one and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

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.

_____

Applicant's Signature Date Signed

_____

Owner's Signature (if other than Applicant) Date Signed

_____

Signed in (city, state)

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Tier One may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Tier One may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim, or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our main administrative office.

Please read and print a copy of the Consent Statement for Electronic Transactions, Records, and Signatures (Consent Statement) detailing your rights regarding electronic transactions, electronic signatures, and electronic records. By submitting this request electronically to Tier One, you acknowledge that you have read, understand, and agree to this Consent Statement and the terms and conditions. If you do not wish to proceed and utilize electronic transactions, electronic signatures, and electronic records, please contact Tier One at 1-833-504-0336.

_____

Applicant's Signature

I certify that each question was asked of the Applicant and answered as recorded. All answers are correct to the best of my knowledge.

I certify that I have advised the Applicant to consider the cost and benefits of this Tier One coverage, and I agree with the Applicant's decision that it is appropriate for purchase.

_____ _____

Agent name (*printed)* Writing number *(agent or company)*

_____

Associate's/Agent's/Insurance Producer's Signature Date
licensed Associate/Agent/Insurance Producer

FOR INFORMATION, CALL TOLL-FREE 1.833.504.0336.
VISIT OUR WEBSITE AT AFLAC.COM.

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.

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:_____

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

Account owner signature: _____

Date signed: _____