ELCO MUTUAL
LIFE & ANNUITY
916 Sherwood Drive Lake Bluff, Illinois 60044-2285

INDIVIDUAL LIFE INSURANCE APPLICATION
Please print in dark ink.

1. Proposed Insured

Name: First _____ M.I. _____ Last _____ Birthdate *(mm/dd/yr):* _____/_____/_____

State or Country of Birth: _____ U.S. Citizen: Yes ☐ No ☐ If No, are you a permanent resident: Yes ☐ No ☐

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Height: _____ Weight: _____

Home Address: (Number, Street, Apt. #) _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Social Security Number: _____

Driver's License #: _____ E-mail Address: _____

2A. Owner Information *(if other than Proposed Insured)*

Name: First _____ M.I. _____ Last _____ Birthdate *(mm/dd/yr):* _____/_____/_____

Phone Number: (___) _____ Social Security Number: _____

Sex: Male ☐ Female ☐ E-mail Address: _____

Home Address: (Number, Street, Apt. #) _____ City: _____ State: _____ Zip:_____

Relationship to Proposed Insured: _____

2B.Payor (if other than Owner)

Name: First _____ M.I. _____ Last _____ Email Address : _____

Home Address: (Number, Street, Apt. #) _____ City: _____ State: _____ Zip:_____

Phone Number: (___)-_____ Social Security/Tax ID Number: _____

3. Plan of Insurance, Benefits, Riders

Plan Name/Type: _____ Face Amount: $ _____

Additional Benefits/Riders: _____ * Amount Paid with Application: $ _____

Mode: Single Premium ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Modal Premium: $ _____

Optional EFT Mode: Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐

Dividend option: Reduce Premium ☐ Purchase Addition ☐ Leave on Deposit ☐ Cash ☐

Policy Date: _____/_____/_____ Automatic Premium Loan? Yes ☐ No ☐

4. Beneficiary Designation *(List Full Name(s), Date(s) of Birth and Relationship to Proposed Insured)*

Primary: _____

Contingent:_____

5. Existing Life Insurance Information

Do you have any existing life Insurance policies and/or annuity contracts in force? Yes ☐ No ☐

If Yes, total amount of life insurance in force: $_____ Total amount of annuities in force: $_____

Do you have any other applications pending with any other company? Yes ☐ No ☐

Have you applied for life insurance with any other company in the past two years? Yes ☐ No ☐

Will this application change or replace any existing life insurance policy or annuity policy? Yes ☐ No ☐

If Yes, List company(s): _____

***Make premium checks payable to:** **ELCO Mutual Life and Annuity**

6. Health Questions Part 1. ***Any YES answer to the questions listed in Part 1 will result in additional underwriting.***

1. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living: bathing, toileting, eating, dressing, walking, maintaining continence or transferring form bed to chair? Yes ☐ No ☐
2. Have you ever:
   a. Been treated by a member of the medical profession or hospitalized for: insulin shock, diabetic coma, amputation due to diabetes: or taken insulin injections or taken insulin by other methods prior to age 40; or been diagnosed with diabetes prior to age 25 by a member of the medical profession? Yes ☐ No ☐
   b. Been advised by a member of the medical profession to have an organ transplant; or been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next 12 months; or are you currently hospitalized, confined to a bed or nursing facility; or receiving hospice care? Yes ☐ No ☐
   c. Been diagnosed or treated by a member of the medical profession, or taken medication, for: chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity? Yes ☐ No ☐
   d. Been treated or diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder, or tested positive for the human immunodeficiency virus (HIV)? Yes ☐ No ☐
   e. Been diagnosed or treated by a member of the medical profession for more than one occurrence, or any metastasis, of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer or had an amputation caused by cancer? Yes ☐ No ☐
3. Within the past 24 months have you:
   a. Been declined or postponed for life or health insurance? Yes ☐ No ☐
   b. Been convicted of a felony or are you currently on probation or parole? Yes ☐ No ☐
   c. Been convicted of operating a vehicle while intoxicated or impaired? Yes ☐ No ☐
   d. Participated in any activity of Hang Gliding, Parasailing, Ultra-Light, or racing of Autos, Motor Boats, or Motorcycles? Yes ☐ No ☐
4. Within the past 24 months have you been diagnosed or treated by a member of the medical profession for, or taken medication for:
   a. Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), cirrhosis, liver disease, attempted suicide, alcohol abuse or drug abuse? Yes ☐ No ☐
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, or required oxygen to assist in breathing? Yes ☐ No ☐
5. Within the past 24 months has a member of the medical profession diagnosed you as having, or treated your for, or advised you to have treatment for, or have you been hospitalized for:
   a. Angina, heart disease, heart attack, uncontrolled high blood pressure, heart or vascular surgery (including heart transplant, coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) or any procedure to improve circulation to the heart or brain? Yes ☐ No ☐
   b. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities? Yes ☐ No ☐

Health Questions Part 2.

1. Within the past 48 months have you been diagnosed by or treated by a member of the medical profession for, or hospitalized for, or taken medication for: lymphoma, melanoma, leukemia, any internal cancer, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), cirrhosis, or liver disease? Yes ☐ No ☐
2. Within the past 36 months have you been diagnosed by or treated by a member of the medical profession, or hospitalized for, or taken medications for:
   a. Angioplasty, cardiac or vascular stent placement, angina, heart attack, heart or vascular surgery or any procedure to improve circulation to heart or brain? Yes ☐ No ☐
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, or required oxygen to assist in breathing? Yes ☐ No ☐
   c. Diabetic complications (including neuropathy, retinopathy, uncontrolled blood sugar)? Yes ☐ No ☐
3. Within the past 24 months have you been confined three or more times to a hospital, nursing facility, convalescent care facility or mental facility? Yes ☐ No ☐

Health Questions Part 3.

1. Are you taking any medication for any health impairment in Section 6. Health Questions Part 1 or 2? Yes ☐ No ☐
   If Yes, list medications in the space provided below.
2. Have you used any nicotine based products in the past 12 months? Yes ☐ No ☐
   If Yes, list details in the space provided below.

7. Suitability Question

Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, available funds and retirement considerations? Yes ☐ No ☐

Use the space below to list medications or details to any "Yes" answers from any health questions.

Agent Statement: Does the Proposed Insured have any existing life Insurance policies and/or annuity contracts in force? Yes ☐ No ☐
Will this application change or replace any existing life insurance policy or annuity policy? Yes ☐ No ☐

The information contained in this application is true and accurate to the best of my knowledge. I have delivered to the proposed insured the Insurance Information Practices, which includes the Fair Credit Reporting Act Notice and the MIB, Inc. Pre-Notice.

Agent's Signature *Date*

Medical Authorization: I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc. (formerly known as the Medical Information Bureau), pharmacy benefit manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer, or any other person or organization that has any record of information about me or my minor children to give ELCO Mutual Life and Annuity (the Company), its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information the Company requires to determine insurability or eligibility of benefits.

I also authorize the Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. I further authorize the sources listed above, except for MIB, Inc., to give such information to a consumer reporting agency acting on behalf of the Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its administrative office address.

I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 24 months from the date signed, or the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

Fraud Notice/Warning: 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 the law.

I understand and acknowledge that I have read the Fraud Notice printed above or that it has been read to me.

Proposed Insured/Applicant Statement: I understand all of the questions that I have read or that have been read to me on this application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. All of the statements and answers in this application for life insurance are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for, and will become part of, any policy that is issued by ELCO Mutual Life and Annuity Company (the Company) and that no information about me will be considered to have been given to the Company unless it is stated in the application. I agree that any policy shall not be in effect until it has been issued by the Company and all premiums have been paid.

I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I am not being paid cash and have not been promised services as an inducement to enter into this application. The purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company. I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. notices.

Signed at: _____ _____ this _____ day of _____, 20_____.
City *State* *Day* *Month* *Year*

_____ _____
Signature of Proposed Insured (age 15 & up) *Signature of Proposed Insured's Spouse or Payor*

_____ _____
Signature of Parent for Juvenile Policy *Signature of Owner (if not the Proposed Insured)*

_____ _____
Agent's Signature *Date*

_____ _____
Agent's Printed Name *Agent's Code Number*

_____ _____
Agent's Phone Number *Agent's Fax Number*

_____
Agent's Email Address

ICC16-LA16 (01/17)

PROXY

Do you hereby constitute and appoint the proxy committee of ELCO Mutual Life and Annuity, as established in the bylaws, as your lawful attorney and proxy and in your name and stead hereby authorize and empower it to cast your vote at any meeting of the policyholders of the company? This proxy shall continue in force except when you are present in person or revoke it by giving the company written notice in accordance with the ELCO Mutual Life and Annuity bylaws.

Answer: Yes ☐ No ☐ _____ _____
Proposed Owner's Signature *Date*

ICC14-PROXY 2014 (01/17)