_____
Policy #

Application To:
Monster Life Insurance Company

Affiliation
☐ Union ☐ CU ☐ Assoc.
☐ Globe ☐ POS ☐ Ref
☐ Lics. Prof.

1. Names of Proposed Insureds	D.O.B.	Age	Birthplace	Ht.	Wt.	Sex
Adult						
Child						
Child						
Child						

2. Plan — Face Amt.

☐ WL $_____
☐ PR $_____
☐ EX $_____
☐ _____ $_____

Riders and Benefits
☐ 10 R & C $_____
☐ Child $_____
☐ Spouse $_____
☐ ADB $_____
☐ B2000 $_____
☐ WP $_____
☐ _____ $_____

3. Person to be Owner of Policy ☐ Applicant ☐ Other, give name and relationship

5. Insured's Occupation

4. Address of Owner of Policy

6. Employer's Name

7. Beneficiary — Relationship to Insured

8. Contingent Beneficiary — Relationship to Insured

9. For how much are you now insured?

10. SS#

Company	Amount	Yr. Iss.

11. Driver's License #

12. Medical Records ID #

13. Name and Address of Personal Physician

Date Last Seen

Mode Premium
☐ A ☐ MBD
☐ SA ☐ SS
☐ _____

PLACE AN 'X' IN THE BOX WITH THE CORRECT ANSWER

14. Do you wish the Automatic Premium Loan Provision? ..... Yes ☐ No ☐

15. Is the insurance applied for intended to replace insurance or annuities in this or any other company? ..... Yes ☐ No ☐

16. Has any proposed Insured ever been rejected for life insurance, rated, or failed to receive a policy as applied for? ..... Yes ☐ No ☐

17. Has any proposed Insured ever had or been treated for any of the following conditions:

(a) High blood pressure, chest pain, or any heart or circulatory disorder? ..... Yes ☐ No ☐

(b) Asthma, emphysema, or other respiratory disorder? ..... Yes ☐ No ☐

(c) Ulcer, colitis, or other digestive tract disorder? Yes ☐ No ☐

(d) Cirrhosis,hepatitis, or other liver disorder? ..... Yes ☐ No ☐

(e) Diabetes or other endocrine disorder? ..... Yes ☐ No ☐

(f) Kidney, prostate, urinary bladder or other genitourinary disorder? ..... Yes ☐ No ☐

(g) Paralysis, epilepsy, mental disease or any other nervous system disorder? ..... Yes ☐ No ☐

(h) Cancer, tumor, or unexplained masses? ..... Yes ☐ No ☐

(i) Disease of the breasts, uterus or ovaries? ..... Yes ☐ No ☐

(j) Rheumatoid arthritis or any other musculo-skeletal disorder? ..... Yes ☐ No ☐

(k) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? ..... Yes ☐ No ☐

18. Has any proposed Insured ever been tested positive for antibodies to the "AIDS" (HIV) virus? Yes ☐ No ☐

19. Has any proposed Insured in the last 5 years:

(a) Had a physical examination? ..... Yes ☐ No ☐

(b) Had any medical treatment? (includes prescription medications) ..... Yes ☐ No ☐

(c) Been hospitalized? ..... Yes ☐ No ☐

20. Has any proposed Insured ever been treated for alcoholism or been a member of A.A.? ..... Yes ☐ No ☐

21. Has any proposed Insured ever used alcohol to excess or used narcotics, sedatives, or hallucinogens? ..... Yes ☐ No ☐

22. Has any proposed Insured ever been arrested? Yes ☐ No ☐

23. Does any proposed Insured smoke cigarettes or use tobacco in any other form? ..... Yes ☐ No ☐

24. If a former user of tobacco, when did proposed Insured quit? Date_____

25. Does any proposed Insured use marijuana? ..... Yes ☐ No ☐

If questions 15-25 are answered "yes", give explanations, dates, names & addresses of physicians & hospital (if any) below.

Proposed Insured	Explanation or Medication	Date	Duration	Hospital	Physician	Address
				Yes ☐ No ☐		
				Yes ☐ No ☐		
				Yes ☐ No ☐		

FOR MORE SPACE USE "ADDITIONAL REMARKS" (over)

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

Received of _____the sum of $_____ as first payment on this application.

Date _____ Agent_____

If **(1)** an amount equal to the first full premium is submitted; **(2)** all underwriting requirements, including any medical examinations required by the Company's rules, are completed; **(3)** the proposed insured is on the effective date indicated above a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, (b) the date of completion of all underwriting requirements, and (c) any date of issue requested in the application. THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY SHALL NOT EXCEED $50,000.

If any of the above conditions are not met, the liability of the Company shall be limited to the return of the amount submitted. "ALL CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK."

(SEE NOTICES ON REVERSE SIDE).

INVESTIGATIVE CONSUMER REPORTS NOTIFICATION

As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. You may request to be interviewed in connection with the preparation of the report and upon request may receive a copy of the report.

MIB NOTICE

Information regarding your insurability will be treated as confidential. Monster Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, 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 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Monster Life Insurance Company may also release information in its file to its reinsurers or to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. I also acknowledge that I have received the Investigative Consumer Reports notification and MIB Notice attached to this application.

X _____ _____ _____
Proposed Insured (if 18 or over) Date Phone

X _____ X _____ _____
Signature of Applicant Signature of Agent Agent Last Name AG#

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Monster Life Insurance Company and its reinsurers may obtain medical and other information in order to evaluate my application for insurance. This may be disclosed by any physician, practitioner, hospital, clinic, medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., or any consumer reporting agency, or any insurance company. The information may involve me, or any care, treatment or advice of me. This includes information relating to alcohol or drug abuse, mental disease or information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). American Income may report such information to the Medical Information Bureau or to other insurance companies to which I have or may apply. This authorization will be valid for 2 years. A photocopy of this will be as valid as the original. I, or my authorized representative may receive a copy of this authorization upon request.

X _____ _____
Signature of Proposed Insured (Parent of Insured Under Age 18) Date

AUTHORIZATION FOR PREAUTHORIZED PAYMENTS

Monster Life Insurance Company is authorized to initiate debit entries to the account indicated below, and the depository institution named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the depository will have a reasonable opportunity to act on such notification.

Depository Name: _____ Type of Account: ❒ Checking ❒ Savings
Depository Address: _____
Account #: _____ Transit/ABA #: _____
Name of Policyholder: _____ Withdrawal Day: _____

Signature of Payor: _____ Date: _____

PLEASE ATTACH A VOIDED PERSONAL CHECK

	Face Amount	Premium
Basic Plan		
10 Yr. R&C Term		
Child Rider		
Spouse Rider		
ADB		
B-2000	xxxx	
WP For Basic	xxxx	
WP For Spouse Rider	xxxx	
WP For Other Riders	xxxx	
Total Premium		
Total to Bill		

ADDITIONAL REMARKS OR INSTRUCTIONS
(INCLUDE ADDITIONAL CHILDREN HERE)

Requested draw date, if any:
State in which application signed, if other than address of owner:
Mail Policy To: ☐ Agency ☐ Policyholder
Best time to call:
E-mail address:
Use e-mail for correspondence? Yes ☐ No ☐

AGENT'S STATEMENT

I personally ☐ saw ☐ did not see each proposed insured. Those not seen are listed above under remarks. To the best of my knowledge and belief, the insurance applied for ☐ is ☐ is not intended to replace any insurance now in effect.

X _____
Signature of Agent