Life and/or Disability Application to the Auto-Owners Life Insurance Company

A. ALL APPLICATIONS

Proposed Insured (print full name) | Height | Weight

Social Security No. | Birth Date | Gender

Driver's License No. | Telephone No. ( ) | Alternate No. ( )

Best Time to Call | E-mail Address

Place of Birth (State/Country) | Are you a US Citizen? ☐ Yes ☐ No
If no, please provide valid resident card

Home Street Address

Purpose of Insurance

Employer's Name and Address | Type of Business

Hours Worked/Week | Change in Employment Contemplated? ☐ Yes ☐ No
(If yes, explain)

Occupation (briefly describe job duties) | How Long? (yrs / mths) /

Gross Income $ | Net Income $ | Net Worth $

Beneficiary* (print full name)	Relationship
a. Primary:	
b. Contingent:	

* Will be paid equally to surviving beneficiaries unless specified otherwise

Policyowner and/or Payor (If other than Proposed Insured)

Name of Owner and Relationship ____________

Social Security No. of Owner ____________

Owner's Address: ____________

Name of Premium Payor ____________

Social Security No. of Payor ____________

Annual Net Income of Payor $ ____________

Billing Address ____________

Premium With Application $ ____________

Bill: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (PT2/PT3 only)
☐ Annual EFT ☐ Semi-Annual EFT ☐ Quarterly EFT ☐ Monthly EFT

Planned Payment (PT2/PT3) $ ____________

Home Office Endorsement/Special Requests:

B. ADDITIONAL ADULT INSURED

☐ **Secondary** ☐ **Adult under Spouse and Children's Term Insurance**
(print full name) | Height | Weight

Social Security No. | Birth Date | Gender

Driver's License No. | Telephone No. ( ) | Alternate No. ( )

Best Time to Call | E-mail Address

Place of Birth (State/Country) | Are you a US Citizen? ☐ Yes ☐ No
If no, please provide valid resident card

Home Street Address

Purpose of Insurance

Employer's Name and Address | Type of Business

Hours Worked/Week | Change in Employment Contemplated? ☐ Yes ☐ No
(If yes, explain)

Occupation (briefly describe job duties) | How Long? (yrs / mths) /

Gross Income $ | Net Income $ | Net Worth $

Beneficiary* (print full name)	Relationship
a. Primary:	
b. Contingent:	

* Will be paid equally to surviving beneficiaries unless specified otherwise

C. ALL APPLICATIONS

Complete if Self Employed, Owner of a Business, Contract Employee or Reporting 1099 Income.

1. Average monthly expenses . . . . $____________
2. Net worth of Business . . . . $____________
3. Net Earned Income after business expenses as reported for federal income tax purposes:
   a. Average monthly income for current tax year . . . . $____________
   b. Actual annual income for prior tax year. . . . . $____________
   c. Actual annual income for tax year 2 years ago . . . . $____________
   d. Other Income . . . . $____________
   (explain) ____________
4. Is firm: ☐ Sole Proprietorship ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Other
5. If application is for Business Insurance: Purpose of Application:
   ☐ Keyman ☐ Fund a Buy-Sell Agreement ☐ Split Dollar ☐ Stock Redemption ☐ Deferred Compensation ☐ Other
6. If Partnership, list names of partners ____________
7. Amount of insurance in force or contemplated on other members of firm $ ________
8. Financial Details of Business:

	CURRENT FISCAL YEAR TO DATE ____ through ____	PREVIOUS FISCAL YEAR
a. Total Assets	$ ________	$ ________
b. Total Liabilities.	$ ________	$ ________
c. Gross Sales or Revenue	$ ________	$ ________

9. Percentage of ownership by Proposed Insured _____ %

D. LIFE

Complete when **CHILDREN** are proposed for ☐ Secondary or ☐ Children's or Spouse and Children's Term Coverage

Print Child's Name	Social Security No.	Birth Date	Gender	Amount	Height		Weight	Relationship to Applicant
					Ft.	In.		

Beneficiary (print full name) Will be paid equally to surviving beneficiaries unless specified otherwise	Relationship
a. Primary:	
b. Contingent:	

E. LIFE

Name of Plan ______ Item Number ______

Amount $ ______ (Primary) $ ______ (Secondary) Decreasing Term Period ______ Years

Do you want to be considered for Premier Rates? (24 months tobacco-free) . . . ☐ Yes ☐ No

Additional Benefits:

☐ Disability Premium Waiver (WL, UL, Level & Decreasing Term)
☐ Guaranteed Renewability Benefit (10, 20 Year Level Term)
☐ Premium Waiver for Death or Disability of Payor (WL, UL)
☐ Cost of Living Increase (UL)
☐ Automatic Premium Loan (WL)
☐ Accidental Death Benefit (WL, UL, Level & Decreasing Term) . . . $ ______ amount
☐ Spouse and Children's Term Insurance (WL, UL, Level & Decreasing Term) . . . ______ units
☐ Children's Term Life Insurance (WL, UL, Level & Decreasing Term) . . . ______ units
☐ Guaranteed Purchase Option (WL, UL) . . . $ ______ amount
☐ Disability Income Benefit Rider - complete below (WL, UL, Level & Decreasing Term)

Monthly Benefit Amount $ ______ Elimination Period is 60 Days Occupational Class ______ Benefit Period ______ Years

Other Income $ ______ (explain) ______

F. DISABILITY

Benefit Period: ☐ 2 Years ☐ 5 Years ☐ To age 67 Elimination Period ____ Days Prior Year's Taxable Income $ ______

Occupational Class ______ Monthly Benefit Amount $ ______

1. Percentage of time spent performing:
   a. Professional, managerial or administrative duties _____%
   b. Trade, services or labor _____%
   c. Other _____% (explain) ______
2. Do you have any additional occupations? . . . ☐ Yes ☐ No
3. Do you participate in any volunteer activities? (e.g., volunteer firefighter) . . . ☐ Yes ☐ No
   a. What type of volunteer activities do you participate in? ______
   b. How many hours do you participate in these activities? ______
   c. Are you paid for these activities? . . . ☐ Yes ☐ No
      If yes, annual amount $ ______ (explain) ______
4. Do you work from an office in your home? . . . ☐ Yes ☐ No
   a. How many hours do you work each week in your home office? ______
   b. How many hours each week do you leave your home office to conduct business? ______
   c. Does your office have a separate entrance, distinct from the main residential entrance? . . . ☐ Yes ☐ No
   d. What duties of your occupation are performed away from your office? ______

Additional Benefits:

☐ 3% Cost of Living Increase Rider
☐ Business Owner Return-to-Work Rider
☐ Business Overhead Expense Rider . . . $ ______ monthly benefit amount (complete Business Overhead Expense Addendum)
☐ Coordinating Additional Insurance Rider . . . $ ______ monthly benefit amount
☐ First Day Hospital Confined Rider
☐ Guaranteed Insurability Rider
☐ Own Occupation 5 Year Rider
☐ Own Occupation to Age 67 Rider
☐ Residual Disability Rider
☐ Spousal Catastrophic Disability Rider (complete Spousal Catastrophic Disability Rider Addendum)

G. ALL APPLICATIONS

Please answer the following questions for each Proposed Insured
Give details to yes answers for questions G1, 3, 4 in H6

ONLY COLLECT MONEY AND ISSUE BINDING RECEIPT WHEN ALL ANSWERS TO QUESTIONS 1-4 ARE NO

	Proposed Insured Yes	Proposed Insured No	Additional Adult Insured Yes	Additional Adult Insured No	Children Yes	Children No
1. Do you have or during the past 10 years, have you been diagnosed or treated by any physician or other practitioner for:						
a. Heart disease or disorder, angina, stroke or cancer?	☐	☐	☐	☐	☐	☐
b. Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
2. Are you currently unemployed, retired, laid off or collecting Disability? (explain________________)	☐	☐	☐	☐	☐	☐
3. During the past 5 years, have you been absent from work due to accident or sickness for more than 10 days at a time?	☐	☐	☐	☐	☐	☐
4. During the past 90 days, have you been admitted to or been advised to be admitted to a hospital or medical facility by any physician or other practitioner?	☐	☐	☐	☐	☐	☐
5. Do you have any existing life insurance or annuity policies? (provide details in G7)	☐	☐	☐	☐	☐	☐
If yes, is the policy applied for replacing or likely to replace any existing life insurance or annuity policies?	☐	☐	☐	☐	☐	☐
6. Do you have any Disability Income insurance in force? (provide details in G7). (include salary continuation from employer, union, group DI or State sick pay plan)	☐	☐	☐	☐	☐	☐
If yes, is the policy applied for replacing or likely to replace any existing Disability Income insurance?	☐	☐	☐	☐		

7. Insured's Name	Company	Issue Date	Life Amount	Accidental Death	Disability Income	Benefit Years	Elimination Period

H. ALL APPLICATIONS

Completion of H1-5 is optional for persons who will be medically examined

	Yes	No	Yes	No	Yes	No
1. Are you currently taking medication, receiving treatment or under consultation for any disease, ailment or condition?	☐	☐	☐	☐	☐	☐
2. Do you have or during the past 10 years, have you been treated for:						
a. Disease or disorder of the eyes, ears, nose, throat or mouth?	☐	☐	☐	☐	☐	☐
b. Chest pain, high blood pressure, circulatory system disorder, vascular disease or rheumatic fever?	☐	☐	☐	☐	☐	☐
c. Diabetes, gout, Lupus or thyroid disorder?	☐	☐	☐	☐	☐	☐
d. Epilepsy, seizure, headaches, dizziness, paralysis, multiple sclerosis, Alzheimer's, brain or nervous system disorder?	☐	☐	☐	☐	☐	☐
e. Asthma, sleep apnea, emphysema, chronic obstructive pulmonary disease (COPD) or other lung disorder?	☐	☐	☐	☐	☐	☐
f. Disease or disorder of the kidneys, bladder, genital organs or any part of the urinary tract?	☐	☐	☐	☐	☐	☐
g. Disease or disorder of the stomach, gallbladder, liver, intestines, rectum, or for Crohn's or ulcerative colitis?	☐	☐	☐	☐	☐	☐
h. Arthritis, back trouble, or any disorder of the spine, muscles, joints or bones?	☐	☐	☐	☐	☐	☐
i. Depression, stress, anxiety, nervousness, fatigue, or other mental or emotional disorder?	☐	☐	☐	☐	☐	☐
j. Cancer, tumor, cyst, growth, or disease or disorder of the skin or lymph nodes?	☐	☐	☐	☐	☐	☐
k. Complications from pregnancy or are you currently pregnant?	☐	☐	☐	☐	☐	☐
l. Any other disease, disorder or physical illness?	☐	☐	☐	☐	☐	☐
3. Have you had any other illness, operation or condition not shown above which in the past 10 years:						
a. Caused you to consult any physician or other practitioner? (including all specialists such as a cardiologist, psychologist, chiropractor, etc.)	☐	☐	☐	☐	☐	☐
b. Required home care or confined you to a hospital, sanitarium, clinic, adult day care, assisted living facility or nursing home?	☐	☐	☐	☐	☐	☐
c. Required an x-ray, electrocardiogram, stress test, medical test, laboratory test or study?	☐	☐	☐	☐	☐	☐
d. Been advised by any physician or other practitioner to have any additional diagnostic testing, hospitalization or surgery which was not completed or do you have any results pending?	☐	☐	☐	☐	☐	☐

H. ALL APPLICATIONS

	Yes	No	Yes	No	Yes	No
4. During the past 10 years, have you:						
a. Used cocaine, heroin, LSD, marijuana, PCP or any other hallucinogenic or narcotic drug?	☐	☐	☐	☐	☐	☐
b. Received treatment for alcohol or drug abuse or addiction or been advised by any physician or other practitioner to limit the use?	☐	☐	☐	☐	☐	☐
c. Used illegal drugs or do you currently?	☐	☐	☐	☐	☐	☐
5. Is there any family history of Alzheimer's, diabetes, cancer, heart, Huntington's, kidney or other hereditary diseases? (if yes, list age at diagnosis of father, mother, brothers, sisters)	☐	☐	☐	☐	☐	☐

6. **DETAILS to yes answers** for questions G1, 3, 4 and H1-5

Ques. No.	Name	Condition	Date	Medication (name & dose)	Surgery (type & date)	Results	Attending Physician and/or Hospital Name Address

7. For each Proposed Insured please provide:	**Individual Insured**	**Additional Insured**	**Children**
Name and Address of Personal Physician			
Date and reason last seen			
Medications			

I. ALL APPLICATIONS

Please answer the following questions for each Proposed Insured.

	Yes	No	Yes	No	Yes	No
1. During the past 5 years, have you:						
a. Been refused, rejected, rated or postponed for Life and/or Disability Insurance?	☐	☐	☐	☐	☐	☐
b. Been a member of any armed forces or military or have plans to in the future?	☐	☐	☐	☐	☐	☐
c. Made or contemplated making flights as pilot, student pilot or crew member? (If yes, complete Section K)	☐	☐	☐	☐	☐	☐
d. Participated in any hazardous avocation such as sky diving, scuba diving, hang gliding, any type of organized motor vehicle racing, mountain or rock climbing, or rodeo?	☐	☐	☐	☐	☐	☐
e. Been convicted of driving while impaired or intoxicated, reckless driving, or 3 or more speeding violations?	☐	☐	☐	☐	☐	☐
f. Been convicted of or are awaiting trial for any crime other than a misdemeanor, including currently being on parole or probation? (if yes, please explain and provide date and location)	☐	☐	☐	☐	☐	☐
g. Made a claim for benefits to any insurance company or to the Veterans Administration because of an illness or injury?	☐	☐	☐	☐	☐	☐
h. Traveled, lived or worked outside the US or Canada or have plans to in the future? (if yes, please explain)	☐	☐	☐	☐	☐	☐
2. Is any other Life and/or Disability application pending with any company?	☐	☐	☐	☐	☐	☐
3. Have you smoked one or more cigarettes within the last 12 months?	☐	☐	☐	☐		
a. Have you used tobacco in any form within the last 24 months? (If yes, explain) ____	☐	☐	☐	☐		

4. **DETAILS to yes answers** for questions I1 - 3 (Indicate Question No. and Identify Person)

J. ALL APPLICATIONS

IT IS UNDERSTOOD AND AGREED: (1) That all answers to the questions on **this application** are complete and true to the best of my (our) knowledge and/or belief. (2) That all answers to such questions, together with this agreement, shall form the basis and become a part of any policy issued. (3) In consideration of the application and premium payment, insurance benefits applied for shall take effect on the date of the application subject to terms and limitations of the Binding Receipt; otherwise, benefits shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability, as stated in the application, of the person(s) to be insured. (4) That acceptance of any policy issued on this application will constitute a ratification of any correction in or addition to this application made by the Company and noted in the space for Home Office Endorsement, provided, however, no change shall be made as to amount, classification, plan of insurance or benefits, unless agreed to in writing. (5) Only the President, Vice President or Secretary of the Company can make, modify, alter or discharge contracts or waive any of the Company's rights or requirements.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration 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 to Auto-Owners Life Insurance Company, its reinsurer(s) or insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. 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 Auto-Owners Life Insurance Company 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 Auto-Owners Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and 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 providing written notification to Auto-Owners Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already replied on this Authorization to disclose information about me or to the extent that Auto-Owners Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Auto-Owners Life Insurance Company except as authorized by me or as required by law.

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, Auto-Owners Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I AUTHORIZE my employer, any consumer reporting agency, other organization, institution or person having any records or knowledge of me or my health to release any financial or personal details to Auto-Owners, its reinsurer(s) or insurance support organizations and their representatives. This information may be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this Authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of NOTICE OF INSURANCE INFORMATION PRACTICES. I acknowledge possession of the binding receipt for Life and/or Disability Income insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations, to which I agree, have been explained to me fully.

THE AGENT AND I CERTIFY that I have read, or the agent has read to me, the completed application. I realize that any false statement or misrepresentation in my application may result in loss of coverage under the policy (subject to the incontestability provision, time limit on certain defenses and legal proceedings).

☐ I received the Outline of Coverage. (For Disability Income insurance)

☐ I wish to have an interview if an investigative consumer report is made for this application.

Signed in the state of ______________________ this ________ day of ________________, ___________

I certify information supplied by the applicant has been accurately recorded on the application.

(Signature of Proposed Insured)

(Signature of Additional Adult Insured Over Age 15)

(Agent's Signature)

(Signature of Owner/Applicant — If Other Than Proposed Insured) (Social Security Number / FEIN)

(Agent's Name — Please Print) (Agency & Producer Codes)

(Policyowner Name, Address, and Relationship — Please Print)

K. ALL APPLICATIONS

AVIATION SUPPLEMENT (complete only if Section I1c is answered yes)

FLIGHTS AS: ☐ **PILOT** ☐ **CREW MEMBER**

NAME:	**HOURS FLOWN** PAST 12 MOS.	**HOURS FLOWN** 1 - 2 YRS. AGO	**HOURS FLOWN** NEXT 12 MOS.
Non-Scheduled - Commercial			
Private - Personal - Business			
Student			
Crop Dusting, Fire Fighting, Aerobatics			
Testing or Experimental			
Military (Type _______ Service _______)			
Helicopter, Pipeline or Powerline Insp.			
Charter, Taxi, Bush			
Glider, Balloon, Ultralight			

Remarks:

1. Type of certificate(s) held?
   ☐ Private ☐ Student ☐ ATR ☐ IFR
   ☐ Comm'l ☐ Instructor ☐ Other
2. Total number of pilot hours? ________________
3. Have you had any flying accidents? ________________
   (explain) ________________
4. Ever been grounded or had license revoked? ________
   (explain) ________________
5. Are you a member of, or do you contemplate joining a military air force or reserve? ________________
   (explain) ________________
6. **Coverage desired (check one)**
   ☐ **Aviation Restriction Rider**
   ☐ **Full Aviation Coverage**
7. Indicate type of aircraft flown ________________

L. AGENT'S REPORT FOR ALL APPLICATIONS

1. If rules require, did you arrange? .... ☐ Yes ☐ No
   ☐ Exam ☐ EKG ☐ TVC ☐ Blood Profile ☐ Specimen
   Examiner Name ________________________________
   ____
   ____
2. How long and how well have you known the Proposed Insured?
   (If related, explain) ________________________________
   ____
3. Did you see the Proposed Insured? .... ☐ Yes ☐ No
   If no, please explain ________________________________
   ____
   (Age 18 and older-an Auto-Owners representative is required to see the Proposed Insured when applying for coverage. If you cannot meet with the Proposed Insured to verify the identity and review the answers for accuracy, please arrange to have a paramedic examination performed instead.)
4. To the best of your knowledge, does the applicant have any existing life insurance, annuity or disability income policies? . . . ☐ Yes ☐ No
   Will the insurance applied for replace any existing life insurance, annuity or disability income policies? .... ☐ Yes ☐ No
   Is this a 1035 exchange? .... ☐ Yes ☐ No
5. a. Is the Proposed Insured a dependent? .... ☐ Yes ☐ No
   If so, how much insurance do the parents carry? ________________
   ____
   b. If the Owner is other than the parents, give name, occupation and amount of insurance in force ________________
   ____
   c. Are brothers and sisters insured for a like amount? . . . ☐ Yes ☐ No
   (If no, please explain) ________________________________
   ____
   d. If the Proposed Insured is married, how much insurance does the spouse carry? $________________
6. I have removed and presented the NOTICE OF INSURANCE INFORMATION PRACTICES to the owner. .... ☐ Yes ☐ No
7. Does Proposed Insured(s) have other Auto-Owners Insurance in force? .... ☐ Yes ☐ No
   (If yes, please list) ________________________________
   ____
8. OTHER INFORMATION:

BINDING RECEIPT FOR LIFE AND/OR DISABILITY INCOME INSURANCE

NOTICE: No Binding Receipt shall be issued and no insurance will take effect with respect to any rider, or if questions G1a, G1b, G2, G3 or G4 are left blank or are answered yes with respect to anyone applying for coverage or when life insurance benefits applied for on any person on this and all other pending applications with Auto-Owners Life Insurance Company exceeds $1 million.

Auto-Owners Life Insurance Company has received $________________

with the application for life insurance on__________________________

and any others named in the application and/or $ __________________

for disability income insurance on ___________________________

In consideration of the application and premium payment, death and/or disability benefits applied for shall take effect on the date of the application, subject to the following terms and limitations:

1. No person under the age of 15 days is included under this Binding Receipt for life insurance. No person under the age of 18 years or over the age of 60 years is included under this Binding Receipt for disability insurance.
2. There are no life and/or disability benefits under the Binding Receipt if:
   a. during the past 10 years, anyone applying for insurance has been diagnosed or treated by any physician or other practitioner for or had any knowledge of:
      - heart disease or disorder, angina, stroke or cancer; or
      - Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); or

   b. during the past 90 days, anyone applying for insurance was admitted to, or was advised to be admitted to, a hospital or medical facility by any physician or practitioner; or
   c. the application contains any material misstatements or material misrepresentations; or
   d. death is by suicide.
3. There are no disability benefits under this Binding Receipt if, during the past 5 years, anyone applying for this coverage has been absent from work due to accident or sickness for more than 10 days at a time or is currently unemployed or laid off.
4. Until the application is approved as applied for or insurance under this Binding Receipt ends:
   a. the total life insurance death benefit for anyone included under this Binding Receipt will not exceed the lesser of all death benefit amounts applied for or $250,000.
   b. the total monthly disability benefit for anyone included under this Binding Receipt will not exceed the lesser of all disability benefits applied for or $1,000 per month. Disability benefits are payable for a period of total disability that begins due to an accident that occurs or sickness that first manifests itself after the date of the application. Benefit payments begin following the elimination period specified in the application and will continue during total disability for 120 days.

TO BE DETACHED AND RETAINED BY PROPOSED INSURED

NOTICE OF INSURANCE INFORMATION PRACTICES

This life and disability insurance form gives personal data about the persons to be covered. Sometimes, we may need to seek more personal data from other sources. If we ask for an investigative consumer report, you have the right to ask for an interview with the reporting agency. All such personal data is treated as confidential. In some cases, however, that data may be disclosed to others without an authorization. You have a right of access to this personal data. You may also correct any errors in the data we might collect. You can learn more about these rights and our practices upon request.

MIB, INC.

Information regarding your insurability will be treated as confidential. Auto-Owners Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you 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 is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Auto-Owners Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

You need to know that when you apply for insurance with us, we may ask for a report from a consumer reporting agency. That report could include interviews with you, your neighbors, friends, etc. What we learn is used to determine insurability. It may cover data as to character, reputation, personal characteristics and mode of living. Data gathered for such a report may be kept by the agency preparing it and disclosed to others.

BINDING RECEIPT FOR LIFE AND/OR DISABILITY INCOME INSURANCE CONTINUED

5. Insurance under this Binding Receipt ends when any one of the following happens:

   a. a policy is offered to the policyowner that is different than applied for. Death and/or disability benefits offered shall not take effect until the policy is delivered to the owner and the first premium paid during the lifetime and continued insurability, as stated in the application, of the person(s) to be insured; or

   b. the tenth day after the date Auto-Owners Life Insurance Company mails notice of termination of the Binding Receipt to the applicant at the address given in the application; or

   c. the applicant is personally given notice of termination of the Binding Receipt by an authorized representative of Auto-Owners Life Insurance Company; or

   d. 120 days have passed since the date of this Binding Receipt.

6. If the application is approved as applied for, death and/or disability benefits provided under this Binding Receipt shall be replaced by death and/or disability benefits applied for to take effect on the date of the application.

7. This Binding Receipt and the application are the entire agreement between Auto-Owners Life Insurance Company and the applicant.

8. The premium submitted with the application will be refunded if the policyowner does not accept the policy, if Auto-Owners Life Insurance Company declines to issue a policy or when the 120 day period has passed. Any premium payment due and unpaid will be deducted from any death and/or disability benefits payable under this Binding Receipt.

Date ______________________

Applicant's Signature ______________________

Auto-Owners Life Insurance Company
Lansing, Michigan 48909

Agent's Signature ______________________

If you write to us, we will tell you if such a report was made. We will also tell you the nature and scope of the report. This will be done in a reasonable time once we receive your letter. We will also tell you who made the report. You can then contact them for a copy of the report.

MEDICAL RECORD INFORMATION

We underwrite each application to help keep the price reasonable. This also helps each person to pay a fair share of the cost in line with the risk each represents. To do this we ask about your physical or mental illness, medical history or treatment. Your application gives some of these answers. We may ask your doctor, hospital, etc., for more details. We may ask you to take an examination. You have the right to amend or correct any personal information we collect. Write us if you want to do this: Auto-Owners Life Insurance Company, Life Underwriting, P.O. Box 30325, Lansing, MI 48909-7825.

AUTHORIZATION AND ACKNOWLEDGEMENT

I AUTHORIZE the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. It may also concern my child or my child's health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism or mental illness. This will be used by underwriters, Company Officers and medical personnel to evaluate claims. They may also use it to consider life or disability insurance and/or benefits applied for by me.

Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration and the MIB, Inc. may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who may have information of care, treatment or advice about me or my child may also release it.

I UNDERSTAND that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid.

I ACKNOWLEDGE having received a copy. I also received a copy of the NOTICE OF INSURANCE INFORMATION PRACTICES.

INSURANCE FRAUD

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.