Leaders Lifestyle with Critical Illness

LeadersLife WORKSITE BENEFITS

Term Life Insurance to Age 100 with 30% Critical Illness Benefit

ENROLLMENT APPLICATION

NOTICE TO APPLICANT

PLEASE DETACH AND HAND TO APPLICANT - FAIR CREDIT REPORTING ACT OF 1970 - This is to inform you that as part of this Company's procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputations, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MEDICAL INFORMATION BUREAU NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information you provide will be treated as confidential except that the Leaders Life Insurance Company, or its reinsurers, however, makes a brief report to the Medical Information Bureau, a non-profit membership organization or life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply such company with the information it may have in its files.

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, MA 02184-8734, telephone number (781) 751-6000.

Leaders Life Insurance Company, or its reinsurers, may also release information in its files 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.

Policy Form LL-19.1 (rev 6/12)

LEADERS LIFE INSURANCE COMPANY
P.O. BOX 35768
TULSA, OKLAHOMA 74153

ACCELERATED BENEFIT DISCLOSURE

The Accelerated Benefit provides a one time advance of specified percentage of the Amount of Insurance shown on the Policy Schedule of the policy or $250,000, whichever is lower upon occurrence of one of the following life threatening conditions:

HEART ATTACK: (Myocardial Infarction): The death of a portion of heart muscle (myocardium): (1) Resulting from a blockage of one or more coronary arteries; and (2) Requiring hospital confinement for at least three consecutive days.

STROKE: Any acute cerebral vascular accident: (1) Producing Neurological impairment; (2) Resulting in paralysis or other measurable objective neurological deficit persisting for at least 30 days; and (3) Requiring hospital confinement for at least three consecutive days.

CARDIAC SURGERY: The actual undergoing of: (1) Bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease; or (2) Heart transplant surgery, including the use of an artificial heart.

LIFE-THREATENING CANCER: Only those types of cancer manifested by the presence of a malignant tumor characterized by: (1) The uncontrolled growth and spread of malignant cells; and (2) The invasion of tissue. As used here, Leukemia and Hodgkin's Disease (except Stage 1 Hodgkin's Disease) shall be considered life-threatening cancer.

LIFE-THREATENING CANCER DOES NOT INCLUDE: Any pre-malignant tumors or polyps, cancer in situ, intraductal non-invasive carcinoma of the breast, carcinoid of the appendix, Stage 1 transitional carcinoma of the urinary bladder, or any skin cancers other than melanoma.

TERMINAL ILLNESS: An illness or physical condition, that manifests itself on or after the 30th day following the policy date of the Policy that can reasonably be expected to result in death in two years or less.

- The amount paid will reduce the death benefit and premium of the policy by the percentage of the Accelerated Benefit payout.
- A processing charge of $150 will be deducted from the Accelerated Benefit payment.

If any death benefit remains after payment of an Accelerated Benefit, the accidental death benefit provided under an accident rider attached to this Policy, if any, will not be affected by the payment of an accelerated benefit.

Disclosure Related to Tax Qualification of Accelerated Benefits

The accelerated benefit offered under this Policy may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the accelerated benefit qualifies for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive accelerated benefits excludable from income under federal law.

Disclosure Related to Accelerated Benefits' Effect on Public Assistance

Receipt of accelerated benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Proposed Insured Signature: _____

Owner (If other than Proposed Insured) Signature _____

Agent Signature _____

Date _____

LIFE INSURANCE APPLICATION

Employee (Owner) _____ SS NO. _____

Email Address _____

Address _____ Telephone Number _____

Street City State Zip

Employer/Sponsor _____ Date of Hire _____

1. Proposed Insured (Print Full Name)	☐ Male ☐ Female	Relationship to Employee (Owner)
U. S. Citizen? ☐ Yes ☐ No	If No, Please Provide Green Card/Visa No.	

(The contingent owner of the policy shall be the Proposed Insured unless otherwise stated.)

2. Date of Birth	Current Age	State of Birth	3. Height: ____ ft. ____ in. Weight: _____ lbs.	4. Job Title & Description

POLICY INFORMATION	5. Plan:	Insurance Amount	Dividend Option	Premium

6. Accidental Death Benefit (Double Indemnity) - Primary Insured Only ☐ Yes ☐ No

7. Children's Term Rider ($10,000 of Coverage) ☐ Yes ☐ No U. S. Resident? ☐ Yes ☐ No
All *unmarried Dependent children of the proposed insured* (Question #1) who are age 30 days to the age of 26 (Coverage ends on 26th birthday). The beneficiary of children's coverage is, in all cases, the Proposed Insured.

Total Premium:

Name (Please Print)	DOB	Birth State	Ht.	Wt.	Name (Please Print)	DOB	Birth State	Ht.	Wt.
(1)	/ /				(4)	/ /			
(2)	/ /				(5)	/ /			
(3)	/ /				(6)	/ /			

8. Name of Beneficiary and Relationship (If incomplete, proceeds will be paid to estate of Insured.)	Home Office Use Only

		YES	NO
9.	Have any of the Proposed Insureds (including Children) in the last 10 years had or been told by a medical professional that they had:		
A.	Heart Disease, Stroke, Chest Pains, Respiratory Disorder, including Asthma and Tuberculosis?		
B.	Liver Disease, or any Digestive Disorders including Ulcer or Intestinal Disease, Diabetes, Disorder of the Kidney or Bladder or Blood or Sugar in the Urine?		
C.	Cancer or Tumor (including Hodgkin's Disease and Leukemia)?		
D.	Nervous or Mental Disorder, an Alcohol or Drug problem or ever sought advice, treatment or been arrested for use of such, ever been convicted of a felony or of driving while intoxicated, or had 2 or more moving violations in the past 5 years, or ever had a license suspended or revoked?		
E.	Any deformity or injury or medical or surgical treatment or advice in the past five years or any departure from good health not stated above or have any Proposed Insureds (including Children) had any application for life or health insurance declined, rated or postponed?		
10.	Have any of the Proposed Insureds (including Children) ever been medically diagnosed or treated as having "AIDS" (Acquired Immune Deficiency Syndrome). AIDS Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV) or Human T-lymphotrophic Virus Type III (HTLV) prior to today?		

If "YES" to any part of No. 9 or 10, Please provide name of proposed insured, question #, date of diagnosis, medication/dosage, current status/problems, date last treated and physician's name. (Add additional sheets if necessary)

If "YES" to No. 9 D, state the name of Proposed Insured (policy or rider) and provide details:

Name DL No. Date Details Type of Offense Sentence Probation Info.

Current Life Insurance

Do you currently have life insurance from another carrier? ☐ Yes ☐ No (If yes, list all policies in box 11 below)

Current Life Insurance				
11.	Company:	Amount:	Date Issued:	Purpose: ☐ Business ☐ Personal
	Company:	Amount:	Date Issued:	Purpose: ☐ Business ☐ Personal
Replacement				
12.	Is this policy to replace any existing life insurance or annuity?	☐ Yes (complete applicable replacement form)		☐ No
Pending Applications				
13.	Are there life insurance applications pending with other companies?	☐ Yes	☐ No	

AUTHORIZATION. I AUTHORIZE: (a) any health plan, physician, healthcare professional, medical practitioner, hospital, clinic, laboratory, pharmacy or pharmacy related facility, medical facility, or other healthcare provider that has provided payment, diagnosis, treatment, care or services to me or on my behalf ("My Providers"); and (b) any insurance company, the Medical Information Bureau, Inc. (MIB), or other organization, institution or person that has records or knowledge of me or my health ("Other Persons"); to disclose my entire medical record, knowledge of my health and any other protected health information concerning me as permitted by law and the Rules of MIB, Inc. to the Company, its agents, employees, representatives, reinsurers and any medical or pharmaceutical records retrieval service the Company may engage. This includes information on the diagnosis and 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 terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

The use of disclosures authorized by this document is for the purpose of allowing the Company to: (1) underwrite my application for coverage, make risk rating determinations, and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the 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 sending a written request for revocation to Leaders Life Insurance Company, P.O. Box 35768, Tulsa, OK 74153, Attention: Privacy Officer.

I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company 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 by the receiving party (including the reporting of protected health information to MIB) and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application.

I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I ACKNOWLEDGE receipt of the replacement notice (if applicable).

I ACKNOWLEDGE that (if applying for life insurance with accelerated benefits)I have received the Accelerated Benefit Disclosure.

I AUTHORIZE Leaders Life Insurance Company, or its reinsurers to make a brief report of my personal health information to MIB.

I represent that all statements and answers in this application are complete, true and correctly recorded to the best of my knowledge and belief and that I have appropriate knowledge to answer the questions for my spouse and children. The policy with this application will constitute the entire insurance contract. If the proposed insured, spouse and any children proposed for insurance are deemed insurable as standard rates, the insurance will become effective on the date this application is signed; otherwise, the insurance will not take effect until a policy is issued and the first premium paid. As owner/insured, my signature authorizes payroll deduction of premium from my employer for myself and my family members.

NOTICE: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of a crime and may be subject to fines and imprisonment.

Applicable to AL residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Applicable to OK residents: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicable to AR and LA residents: Any person who knowing presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable to KS residents: Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information may be guilty of insurance fraud as determined by a court of law.

Signed at (City) _____ State _____ This _____ Day of _____ 20 _____

X _____ X _____

Signature of Proposed Insured | Owner (if other than Proposed Insured)

X _____

Official Capacity (if signed on behalf of a corporation, trust, etc.)

I represent to the best of my knowledge the answers to the questions in all parts of this application are true and correct. I further represent that to the best of my knowledge this policy ☐ *will* ☐ *will not* replace or change any existing life insurance or annuity policy now in force.

AGENT #1 (print name) _____ SIGNATURE _____ AGENT # _____

AGENT #2 (print name) SIGNATURE AGENT #