**MOUNTAIN LIFE INSURANCE COMPANY**
**P.O. BOX 240, ALCOA, TENNESSEE 37701-0240**
**800-888-6542**
**GROUP CREDITOR-DEBTOR INSURANCE**

| PROPOSED INSURED DEBTOR | PROPOSED JOINT INSURED DEBTOR | EFFECTIVE DATE | CERTIFICATE NUMBER |
|---|---|---|---|
| | | | |

## APPLICATION FOR GROUP CREDIT LIFE AND DISABILITY INSURANCE

This Application Is To Be Used Only In Cases Where Evidence of Insurability Is Required

You have the option to buy this insurance from any Company or agent of your choice or to assign a policy, which you now have. It is understood that you freely apply for the coverage shown in the schedule above.

Your Creditor may deduct the amount of premium for this insurance from the proceeds of your loan.

| | Proposed Insured Debtor | Proposed Joint Insured Debtor |
|---|---|---|
| | Height______ Weight______ | Height______ Weight______ |
| 1. Have you been in a hospital for any observation, operation or treatment, or consulted or been treated by any physician or other medical practitioner during the past twelve (12) months? | ☐Yes ☐No | ☐Yes ☐No |
| 2. Are you now disabled, receiving treatment of any kind or contemplating an operation? | ☐Yes ☐No | ☐Yes ☐No |
| 3. During the past ten years have you been treated for or advised by a licensed physician that you had any of the following: disease of heart, blood, lungs, liver, or kidneys; any mental, nervous, circulatory, or digestive disorder; high blood pressure; cancer or tumor; diabetes; drug or alcohol abuse; AIDS, ARC (AIDS Related Complex), or tested positive on an AIDS related blood test; disorder of the back, neck, spine or joints? | ☐Yes ☐No | ☐Yes ☐No |
| 4. Are you currently working at least 30 hours per week? | ☐Yes ☐No | ☐Yes ☐No |

Your subsequent unemployment or retirement during the term of coverage will not be used to deny an otherwise valid claim.

(If the answer to any of the questions is yes, give details below)

| Condition(s) | Date | Names, Addresses & Telephone Numbers of Attending Physicians |
|---|---|---|
| | | |
| | | |

NOTE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **(In Arkansas)** Any person who, with intent to defraud or knowing that he 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.

I voluntarily apply for the insurance on the attached certificate. I declare and agree that to the best of my knowledge and belief that the answers to the above questions are complete and true. As a condition of coverage, I certify that I am now free from any disease or physical impairment.

I understand that this Application is subject to approval. If it is approved, the Application will become a part of the certificate to which it is attached. Upon acceptance of the insurance and within 30 days of the incurred indebtedness, the Insurer shall cause a certificate of insurance to be delivered to you. If the insurance is not approved, any premium paid will be refunded. However, if a valid claim arises before action has been taken, insurance will not be denied for lack of insurability.

## AUTHORIZATION

I hereby authorize any individual, physician, medical practitioner, hospital, clinic or other medical related facility, Medical Information Bureau, insurance company, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurers or their representatives any information related to the health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse, AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered. A Photocopy of this authorization shall be considered as valid as original. This authorization shall be valid for a period of one year from the date of signature.

**PROPOSED INSURED DEBTOR**

Date of Birth ______________________ Birthplace (State) ______________________

Month/Day/Year

Occupation______________________________________________

**Signature**________________________________Date_____________

**PROPOSED JOINT INSURED DEBTOR**

Date of Birth ______________________ Birthplace (State) ______________________

Month/Day/Year

Occupation______________________________________________

**Not Eligible For Disability Insurance**

**Signature**__________________________________Date____________

**Witness**____________________________________ Date_____________
Creditor/Agent

**FOR HOME OFFICE USE ONLY**

Approved_______By_______________________________
Declined_______ Date_____________________________

**GA-CR-0503-APP**

To obtain further information contact:
**Risk Selection Department**
**Mountain Life Insurance Company**
**P.O. Box 240**
**Alcoa, Tennessee 37701-0240**

## NOTICE OF INFORMATION PRACTICES
### Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you. We use this information in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics, and mode of living. This may be obtained through interviews with family members, friends, neighbors, and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information. The information will be sent upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact. We will also provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We usually will not disclose information about you without your prior written authorization. However, in certain situations we may disclose some of this information about you to third parties having a business interest in an insurance transaction involving you, or having a contract with us to perform part of our insurance function. This could include disclosures to persons or organizations that will use the information for sales purposes. However, if you indicate to us that you do not want the information disclosed for this purpose, we will honor your request.

You have the right to obtain access to certain items of information we have collected about you. You have the further right to request the correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the above address.

**MIB, Inc. Notice**
While the information you provide to us regarding your insurability is treated as confidential, Mountain Life may make a brief report thereon to the Medical Information Bureau (MIB or MIB Inc.), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, MIB Inc., upon request from that member company, will supply the information in its file.

Upon written request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedure 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. MIB can be reached by telephone at (866) 692-6901 (TTY (866) 346-3642) or through the www.mib.com website. Information for consumers about MIB may be also obtained through the website.

We may also release information in our file to our reinsurers and to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

**MOUNTAIN LIFE INSURANCE COMPANY**
**P.O. Box 240**
**Alcoa, Tennessee 37701-0240**
**800-888-6542**

# Medical Records Release Authorization

**Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

***Circle the purpose(s)***

1) **Determining eligibility for insurance;**
2) **Determining benefits payable on a disability claim;**
3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

This Authorization will expire on _________________________, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

**A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).**

| ______________________________________________ | ______________________________ |
| --- | --- |
| **Signature of Individual Whose Information is to be Disclosed or Authorized Representative** | **Date of Birth** |

| ______________________________________________ | ______________________________ |
| --- | --- |
| **Print Name of Individual** | **Date** |