MOUNTAIN LIFE INSURANCE COMPANY
2416 Sir Barton Way Suite 110, Lexington, KY 40509
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? Your subsequent unemployment or retirement during the term of coverage will not be used to deny an otherwise valid claim.	☐ Yes ☐ No	☐ Yes ☐ No

(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:

Mountain Life Insurance Company
2416 Sir Barton Way Suite 110
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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.

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Proposed Insured (Please print)	Social Security Number	Birth Date

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 Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also 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. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

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 Mountain 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 Mountain 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 Mountain 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 Mountain 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 that is 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 Mountain 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, Mountain 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, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and 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 receipt of the Conditional Receipt, if applicable, for Life and/or Disability 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.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)

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Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)