

USA LIFE ONE INSURANCE COMPANY OF INDIANA
P.O. Box 609, Fishers, IN 46038
APPLICATION FOR LIFE INSURANCE

Please Print

For assistance with this application, call toll free **1-800-874-0709** weekdays 9am to 5pm Eastern Time
Once approved, your policy will be delivered to you by mail.

1. First Name: _____ Middle Name: _____ Last Name: _____ Date of Birth: _____

2. Address: _____ City: _____ State: _____ Zip Code: _____

3. Home Phone: _____ Work Phone: _____ E-mail Address: _____

4. Social Security Number: _____ Place of Birth: _____ Are You a U.S. Citizen: (Check) YES NO

5. Will this policy replace any existing life insurance or annuity? (Check) YES NO (If yes, give company name and policy number.) Company Name: _____ Policy Number: _____

6. Beneficiary: _____ Relationship to YOU: _____ Phone () _____

6a. Contingent Beneficiary: _____ Relationship to YOU: _____ Phone () _____

HEALTH QUESTIONS: Carefully answer questions 7 through 12 by CHECKING "YES" OR "NO" for any condition(s) that apply.

7. Within the past five years have you been diagnosed with any of the following:
- A terminal illness, Congestive Heart Failure, Cancer or AIDS? YES NO

8. Are you currently in a Hospital, Health Care Facility, or receiving Home Health Care? YES NO

9. Do you need help in taking care of yourself, OR been prescribed to use oxygen? YES NO

10. Within the past five years, have you been treated for chronic Kidney problems or had Dialysis?
 YES NO

11. Have you been advised to have any Medical Treatment or Health Care and not done so?
 YES NO

12. Death Benefit Amount Requested: (Check only one amount)
\$5,000 \$6,000 \$7,000 \$10,000

13. Monthly Premium: \$_____. (See the Monthly Premium Guide)

PLEASE READ AND THEN SIGN IN THE PLACE MARKED "X"

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, which is a **Crime**.

I have read the above application questions and declare the answers are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy. Subject to all conditions set forth in the policy, the insurance shall not be in force until this application has been approved by USA LIFE ONE INSURANCE COMPANY OF INDIANA and the policy is issued and delivered to me, and the first premium is paid while I am in the same health condition as described above. **For Missouri Residents:** We will notify you within sixty days whether or not this application is accepted or provide you the reasons for further delay

PROXY: The undersigned hereby constitutes and appoints the person holding the office of the President of USA LIFE ONE INSURANCE COMPANY OF INDIANA (the Company) as of the date of any meeting referred herein, with full authority to attend any meeting of the policyholders and to vote; in his or her discretion, for the undersigned on any matter that may be presented to a vote of the policyholders of the Company at any annual meeting or any special meeting of the policyholders of the Company. This appointment shall continue in force without limitation as to time, unless revoked by written notice to the secretary of the Company by the undersigned

Signature of

Date: _____ **Proposed Insured "X":** _____ .

IMPORTANT: Before MAILING, COMPLETE ALL QUESTIONS....SIGN ABOVE IN THE PLACE MARKED "X".