



**Headquarters:** 6200 S. Gilmore Road, Fairfield, OH 45014-5141  
**Mailing address:** P.O. Box 145496, Cincinnati, OH 45250-5496  
[www.cinfin.com](http://www.cinfin.com) ■ 513-870-2000

## **Application for Worksite Life Insurance**

**Forms included:**

Worksite Life Insurance Application Form CLI-1025-IIPRC (1/12)  
Guaranty Association Form CLI-6290-MN (2/11)  
Important Notice Form CLI-6273  
Notice of Privacy Practices Form MI1659 (4/12)



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NEW     INCREASE EXISTING POLICY # \_\_\_\_\_ FOR INSURED \_\_\_\_\_

**APPLICATION FOR INDIVIDUAL LIFE INSURANCE**

Please print or type all information

EMPLOYEE	1. Employee (first, middle, last)			2. Employment Date		3. Employee No.	
	4. Mailing Address    No.    Street			Apt. #    City		State    Zip	
	5. Phone No. (H) (    ) (W) (    )		6. Soc. Sec. No.		7. Occupation		
	8. Are you actively at work and currently working at least 20 hours per week? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
	9. Date of Birth		10. St./Ctry. of Birth		11. Gender <input type="checkbox"/> M <input type="checkbox"/> F		
	12. Do you now or have you smoked cigarettes within the last year? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
	13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
	14. Plan		Amount of Ins.		Premium Incl. Rider(s)		15. Mode
	A. <input type="checkbox"/> Term		\$ _____		\$ _____		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly
	B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____		<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly
	C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____		<input type="checkbox"/> Other _____
	D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____		
	16. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> FAIR <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____						
17. Automatic Premium Loan (if available)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No							
18. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____				19. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			
OTHER PROPOSED INSURED	20. Other Proposed Insured (first, middle, last)			21. Other Proposed Insured's Soc. Sec. No.			
	22. Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild			23. Occupation			
	24. Mailing Address    No.    Street			Apt. #    City		State    Zip	
	24. Mailing Address (if different from above)						
	25. Date of Birth		26. St./Ctry. of Birth		27. Gender <input type="checkbox"/> M <input type="checkbox"/> F		
	28. Do you now or have you smoked cigarettes within the last year? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
	29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						
	30. Owner, if other than Employee: (Name and Address)					31. Relationship	
	32. Contingent Owner (Name & Soc. Sec. No.)					33. Relationship	
	34. Plan		Amount of Ins.		Premium Incl. Rider(s)		35. Mode
A. <input type="checkbox"/> Term		\$ _____		\$ _____		<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly	
B. <input type="checkbox"/> Term ROP		\$ _____		\$ _____		<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly	
C. <input type="checkbox"/> Universal Life		\$ _____		\$ _____		<input type="checkbox"/> Other _____	
D. <input type="checkbox"/> Whole Life		\$ _____		\$ _____			
36. Optional Benefit Riders: <input type="checkbox"/> Accelerated Benefit <input type="checkbox"/> CTR - \$10,000 <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Other _____							
37. Automatic Premium Loan (if available)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No							
38. Primary Beneficiary Name: _____ Relationship: _____ City & State: _____				39. Contingent Beneficiary Name: _____ Relationship: _____ City & State: _____			

CTR	40. <b>CHILDREN'S TERM RIDER</b> – All unmarried children who are less than age 19 as of date of application. The beneficiary of children's coverage is, in all cases, the owner.							
	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee	Full Names of Proposed Insured Children	Date of Birth	Gender M or F	Relationship to Employee

(Complete this section only as required by underwriting guidelines.)

CGI	41. <b>CONTINGENT GUARANTEED ISSUE</b> - In the past 90 days have you been hospitalized due to illness or injury or had medical treatment prescribed by a physician? .....	Employee Yes <input type="checkbox"/> No <input type="checkbox"/>		Other Proposed Insured Yes <input type="checkbox"/> No <input type="checkbox"/>	
	<b>IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46</b>				

(Complete this section only as required by underwriting guidelines.)

SI	42. Employee: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____
	43. Other Proposed Insured: Height: _____ ft. _____ in. Weight: _____ lbs.	Primary Physician: Name: _____ Address: _____ City & State: _____

**GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #46**

SI	44. In the past five years, have you:	Employee		Other Proposed Insured		Children (as listed in #40 above)	
		Yes	No	Yes	No	Yes	No
	a. been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for cancer, tumor, stroke, high blood pressure or disease of the heart or blood vessels, kidney disease, diabetes, depression or anxiety, been hospitalized or had hospitalization recommended?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**46. DETAILS OF "YES" ANSWERS:**

DETAILS	Name (Including Children listed in #40)	Date/Duration	Physician and/or Hospital Name and Address	Question Number, Condition, and Treatment

REPLACEMENT	47. Does the Proposed Insured have any life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company? (Complete any applicable replacement forms) .....	Yes	No			
		<input type="checkbox"/>	<input type="checkbox"/>			
	If "Yes," list and indicate if it is to be replaced, changed or borrowed against as a result of this application.		Replaced?			
	Proposed Insured	Insurer	Policy Number	Amount	Yes	No
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

AGREEMENT	<p><b>AGREEMENT: I, the undersigned, agree that:</b> 1. This Application will be part of any policy issued. 2. The answers and statements in this Application are the basis for any policy issued by The Cincinnati Life Insurance Company, and no information about them will be considered to have been given to The Cincinnati Life Insurance Company unless it is stated in this Application. 3. I have read this Application and to the best of my knowledge and belief, all the answers and statements that pertain to me are true and complete. 4. Upon acceptance of a policy other than as applied for, this Application and any amendments shall be for such modified policy. When required by statute or regulation, any change in A. Plan; B. Age; C. Amount; D. Classification; or E. Benefits shall be made only upon written agreement. 5. A sales representative does not have The Cincinnati Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of this Application, policy, or receipt, as applicable. 6. <b>The Cincinnati Life Insurance Company shall incur no liability unless: A. This Application is fully completed, dated, signed and witnessed; B. The first premium due is paid in full or the Payroll Deduction Authorization is completed while each proposed insured is alive; C. The insurability of each proposed insured remains as described in this Application and in any supplements to this Application; and D. A policy is formally approved by us and issued on this Application, and delivered to and accepted by the owner.</b></p> <p>I acknowledge having received and read the Important Notice to the Proposed Insured.</p> <p><input type="checkbox"/> I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.</p> <p><b>Any person who, with intent to defraud or is knowingly facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</b></p> <p>Signed at: _____ City _____ State _____ Signed On: _____ Month _____ Day _____ Year</p> <p>_____ Signature of Employee _____ Signature of Other Proposed Insured (if required)</p> <p>_____ Signature of Owner, if other than Employee</p>
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AGENT	<p><b>For Agent:</b> I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this Application are true and correct. I further certify that to the best of my knowledge and belief, this policy <input type="checkbox"/> <b>Will</b> <input type="checkbox"/> <b>Will Not</b> replace or change any existing life insurance or annuity contract now in force.</p> <p><input type="checkbox"/> I certify no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.</p> <p>_____ Signature of Enrolling Agent _____ Enrolling Agent Name (please print) _____ Enrolling Agent Code #</p>
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**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN  
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH  
INSURANCE GUARANTY ASSOCIATION LAW**

If the Cincinnati Life Insurance Company who issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of The Cincinnati Life Insurance Company. The amount you recover will depend on the financial condition of The Cincinnati Life Insurance Company.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event The Cincinnati Life Insurance Company becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

**Minnesota Life & Health Insurance Guaranty Association  
4760 White Bear Parkway  
Suite 101  
White Bear Lake, Minnesota 55110  
(651) 407-3149**

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

**THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.**

**THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.**

I certify that this Notice was given to the applicant or the policyholder at the time of application.

AGENT

DATE

**COMPLETE TWO FORMS**

**Form CLI-6290-MN (2/11) ONE TO HOME OFFICE – ONE TO APPLICANT/POLICYHOLDER**



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In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event The Cincinnati Life Insurance Company becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

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AGENT

DATE

COMPLETE TWO FORMS

Form CLI-6290-MN (2/11) ONE TO HOME OFFICE – ONE TO APPLICANT/POLICYHOLDER

AGENT: DETACH HERE



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**THE IMPORTANT NOTICE PRINTED BELOW MUST BE  
GIVEN TO THE PROPOSED INSURED**

**IMPORTANT NOTICE TO THE PROPOSED INSURED**

I (We) understand that The Cincinnati Life Insurance Company may obtain an investigative consumer report on me. The data for the report may be obtained through personal interviews with my neighbors, friends, associates or acquaintances. This report includes information about my health, character, reputation, occupation and personal characteristics. I understand that:

1. I may request to be interviewed if an investigative consumer report is obtained;
2. I am entitled to receive a copy of the report; and
3. I have the right to access and request correction with respect to all personal information collected.

Information regarding your insurability will be treated as confidential. The Cincinnati Life Insurance Company, or its reinsurers may, however, make a brief report thereon to the 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Cincinnati Life Insurance Company, or its reinsurers, may also release information from 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](http://www.mib.com).



Cincinnati Financial Corporation and affiliates: The Cincinnati Insurance Company  
The Cincinnati Indemnity Company • The Cincinnati Casualty Company  
The Cincinnati Specialty Underwriters Insurance Company • The Cincinnati Life Insurance Company  
CFC Investment Company • CSU Producer Resources Inc.

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[www.cinfin.com](http://www.cinfin.com) • 513-603-5992

## NOTICE OF PRIVACY PRACTICES

### OUR PRIVACY PLEDGE

You have received this notice because you have a policy with us or you have applied for or purchased a product or service from our family of companies. We believe that your personal information should be respected and protected. For this reason, we are committed to protecting your personal information and using it only as appropriate to provide you with the best possible service, products and opportunities.

This privacy notice describes our information practices and policies. It applies to our relationship with you if you are an individual who inquires about or obtains products or services from us for personal, family or household purposes.

### INFORMATION WE COLLECT

To provide our products or services, we may collect personal information about you from a variety of sources, including:

- information that comes from you during the application process or when visiting [www.cinfin.com](http://www.cinfin.com)
- information about you from our affiliates, your independent insurance agent, governmental entities, consumer - reporting agencies and other sources
- with your prior written consent, a medical professional who has treated you or members of your family

The type of information that we collect depends on the product or service requested, but may include:

- credit history
- motor vehicle reports
- inspections on your property
- claims history
- information concerning your previous insurance policies
- information to properly investigate and resolve any claims

### INFORMATION WE DISCLOSE TO THIRD PARTIES

**We do not sell your personal information to anyone.** We do not disclose your personal information to third parties - people and companies that are not affiliated with us - for their own marketing purposes. For this reason, no "opt-out" is required. If we share some personal information about you with third parties without your specific authorization, it is to provide you with products and services that you request or expect from us, and as otherwise permitted by law.

For example, we may disclose the personal information we collect (as described above) as necessary to:

- service your policy, lease or account
- investigate and pay claims
- comply with state and federal regulatory requests or demands
- process other transactions that you request

To whom we make such disclosures depends on the product or service requested but may include:

- your independent insurance agent
- insurance regulators
- reinsurance companies
- consumer-reporting and fraud prevention agencies
- your mortgage or premium finance company
- insurance adjusters



We also may disclose personal information about you to companies that perform marketing services on our behalf or to other financial service providers with which we have joint marketing agreements. If information is disclosed, it will not result in telemarketing or direct mail marketing.

#### **INFORMATION SECURITY**

We restrict access to personal information about you to those employees who need access to that information in order to provide products and services to you. We maintain physical, electronic and procedural safeguards to guard your personal information.

#### **A SPECIAL WORD ABOUT OUR INSURANCE INFORMATION PRACTICES**

The information in this section applies to you only if you applied for or purchased an insurance product from us for personal, family or household purposes. This section is intended to supplement, but not replace, the other information contained in this Notice of Privacy Practices.

You have the right to access the personal information that we collect about you in connection with your insurance transactions with us. If you believe that any of that information is in error, you have the right to request us to correct it. Send your written request, including your policy number and the information about which you are concerned, to the address listed below.

To receive a more detailed notice regarding our insurance information practices and your information privacy rights, please contact us at the address or phone number given below.

#### **EMAIL COMMUNICATIONS**

We will **not** send you an email in which we ask for personal information from you (such as password or Social Security number) or link you to our website to ask you for such information unless we reference a specific transaction or information that you have requested. If you receive an unsolicited or suspicious email from The Cincinnati Insurance Companies, please forward the email to us at [privacy@cinfin.com](mailto:privacy@cinfin.com).

#### **INFORMATION WE SHARE WITHIN OUR CORPORATE FAMILY**

To serve you, we may share information about our experiences and transactions with you within our family of companies. Such information may include your payment or claims history or the types of insurance coverages you purchase from us.

The following companies comprise the Cincinnati Financial Corporation family of companies:

- Cincinnati Financial Corporation
- The Cincinnati Insurance Company
- The Cincinnati Casualty Company
- The Cincinnati Indemnity Company
- The Cincinnati Life Insurance Company
- CFC Investment Company
- The Cincinnati Specialty Underwriters Insurance Company
- CSU Producer Resources Inc.

This privacy notice applies to and is provided on behalf of all of the companies in the Cincinnati Financial Corporation family of companies with the exception of CFC Investment Company, which is governed by a separate and specific privacy policy.

#### **ONGOING ACCESS TO OUR PRIVACY POLICY**

We will provide a notice of our privacy policy annually, as long as you have a continuing customer relationship with us. This policy may change from time to time, but you can always review our current policy by visiting our website at [www.cinfin.com](http://www.cinfin.com) or by contacting us at:

The Cincinnati Insurance Companies  
Attn: Regulatory & Consumer Relations - Privacy  
P.O. Box 145496  
Cincinnati, Ohio 45250-5496  
Phone: 888-744-2170 (toll free) or 513-603-5992  
Email: [privacy@cinfin.com](mailto:privacy@cinfin.com)