



Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141

Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496

www.cinfin.com ■ 513-870-2000

Application for Worksite Life Insurance

Forms included:

Worksite Life Insurance Application Form CLI-1025-IIPRC (1/12)

Important Notice Form CLI-6273-OK



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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						
	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						
	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. CHILDREN'S TERM RIDER – 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. CONTINGENT GUARANTEED ISSUE - 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"/>	
	IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46				

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

SIMPLIFIED ISSUE

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:

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

In Continuation of Application for Individual Life Insurance

Please print or type all information

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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
	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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AGREEMENT	<p>AGREEMENT: I, the undersigned, agree that: 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. 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.</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>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.</p> <p>Signed at: _____ Signed On: _____</p> <p style="text-align: center;">City State Month Day Year</p> <p>X _____ 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>For Agent: 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"/> Will <input type="checkbox"/> Will Not 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>X _____ Signature of Enrolling Agent _____ Enrolling Agent Name (please print) _____ Enrolling Agent Code #</p>		
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**THE
CINCINNATI LIFE INSURANCE COMPANY**

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

**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. Information for consumers about MIB may be obtained on its website at www.mib.com.

AGENT: **DETACH** HERE