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

☐ 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? .... ☐ **Yes** ☐ **No**
9. Date of Birth
10. St./Ctry. of Birth
11. Gender ☐ M ☐ F
12. Do you now or have you smoked cigarettes within the last year? .... ☐ **Yes** ☐ **No**
13. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? .... ☐ **Yes** ☐ **No**
14. Plan

	Plan	Amount of Ins.	Premium Incl. Rider(s)
A.	☐ Term	$________	$________
B.	☐ Term ROP	$________	$________
C.	☐ Universal Life	$________	$________
D.	☐ Whole Life	$________	$________

15. Mode ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other________________
16. Optional Benefit Riders: ☐ Accelerated Benefit ☐ FAIR ☐ CTR - $10,000 ☐ Waiver of Premium ☐ Accidental Death Benefit ☐ Other ______________
17. Automatic Premium Loan (if available)? .... ☐ **Yes** ☐ **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: ☐ Spouse ☐ Child ☐ Grandchild
23. Occupation
24. Mailing Address (if different from above) — No. Street Apt. # City State Zip
25. Date of Birth
26. St./Ctry. of Birth
27. Gender ☐ M ☐ F
28. Do you now or have you smoked cigarettes within the last year? .... ☐ **Yes** ☐ **No**
29. Do you belong to or have you entered into a written agreement to join the armed forces, including reserves? .... ☐ **Yes** ☐ **No**
30. Owner, if other than Employee: (Name and Address)
31. Relationship
32. Contingent Owner (Name & Soc. Sec. No.)
33. Relationship
34. Plan

	Plan	Amount of Ins.	Premium Incl. Rider(s)
A.	☐ Term	$________	$________
B.	☐ Term ROP	$________	$________
C.	☐ Universal Life	$________	$________
D.	☐ Whole Life	$________	$________

35. Mode ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other________________
36. Optional Benefit Riders: ☐ Accelerated Benefit ☐ Waiver of Premium ☐ CTR - $10,000 ☐ Other__________________ ☐ Accidental Death Benefit
37. Automatic Premium Loan (if available)? .... ☐ **Yes** ☐ **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

CGI

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

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	Employee No	Other Proposed Insured Yes	Other Proposed Insured No
41.	☐	☐	☐	☐

IF "YES", COMPLETE QUESTIONS #42 THROUGH #45 AND GIVE FULL DETAILS IN #46

SI

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

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

44. In the past five years, have you:

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?....

b. been examined or treated by, any member of the medical profession not disclosed in response to the prior question (other than HIV)? ....

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)? ....

	Employee Yes	Employee No	Other Proposed Insured Yes	Other Proposed Insured No	Children (as listed in #40 above) Yes	Children (as listed in #40 above) No
44 a.	☐	☐	☐	☐	☐	☐
44 b.	☐	☐	☐	☐	☐	☐
45.	☐	☐	☐	☐	☐	☐

DETAILS

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

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** ☐

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
				☐	☐
				☐	☐

AGREEMENT

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.**

I acknowledge having received and read the Important Notice to the Proposed Insured.

☐ 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.

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.

Signed at: ______________________________ Signed On: ______________________________

City State Month Day Year

______________________________ ______________________________

Signature of Employee Signature of Other Proposed Insured (if required)

____

Signature of Owner, if other than Employee

AGENT

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 ☐**Will** ☐ **Will Not** replace or change any existing life insurance or annuity contract now in force.

☐ 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.

______________________________ ______________________________ ______________________________

Signature of Enrolling Agent Enrolling Agent Name (please print) Enrolling Agent Code #

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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*.

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PAYROLL DEDUCTION AUTHORIZATION

Employee ______________________ Payroll Number ______________________

Employer ______________________ Agent ______________________

Department ______________________ Agency ______________________

POLICY TRANSACTION

☐ NEW ☐ INCREASE ☐ DECREASE ☐ DISCONTINUE

FREQUENCY: ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY

DEDUCTION AMOUNT PER PAY PERIOD	DATE OF FIRST PAYROLL DEDUCTION	CONTRACT OR CHANGE DATE	FAIR DEDUCTION AMOUNT PER PAY	FAIR DEDUCTION AMOUNT BEGINNING YEAR
$ __________	________, ____	________, ____	$ ______	______

COMPLETE FOR INCREASED, DECREASED OR DISCONTINUED DEDUCTIONS

INSURED	POLICY #
______________________	______________
______________________	______________
______________________	______________

I hereby authorize my Employer to deduct from my salary (wages) the payment as stated above, including any future additional amounts for term rate increases and Future Automatic Increase Rider (FAIR), for the policy(ies) issued by The Cincinnati Life Insurance Company, Cincinnati, Ohio, during the continuance of my employment by said Employer or until this authorization is revoked by me by written notice to the said Employer.

______________________ ______________________ ______________________
Date Signed (mm/dd/yy) Signature of Employee Signature of Witness

WAIVER OF PARTICIPATION

My signature below certifies that I have been made aware of the optional benefit program(s) offered to me through my Employer.

I have decided not to participate in the ☐ **life** and/or ☐ **disability income** insurance program(s) at this time.

______________________ ______________________
Date Signed (mm/dd/yy) Signature of Employee