Gerber Life Insurance

Gerber Life | Simplified Senior Life Insurance

Agent Instructions for Submitting New Application

In addition to the insurance application, the following forms may be required to be submitted at the same time as the application:

The Producer Certification page is part of the Simplified Senior Life application and must be submitted at the same time as the application. The "Insurability of any Person proposed for Insurance" certify statement refers to the responses on the application and not the health of the proposed insured.

Supplement to an Application for Individual Endowment Policy- if owner is different than insured

Replacement Form[1] – if Gerber Life policy will replace another policy, complete appropriate state required form. Form must be submitted with application.

NAIC-Replacement Sales/Marketing Materials Form – In compliance with the NAIC Model Replacement Act, if the Gerber Life policy will replace another policy, the Replacement Sales/Marketing form must be completed. Commissions will be withheld until the document is received.

Accelerated Death Benefit Disclosure Form – The agent, applicant, and owner (if other than insured) must sign the Accelerated Death Benefit Disclosure form. Return the signed appropriate state form with the signed application.

Conditional Receipt – For Check or Money Order ONLY. If check or money order is collected with application, provide Conditional Receipt CRUW to customer and submit copy of receipt with the application and check.*

* In **KS** if a check, money order or authorization of payment is collected with the application, please provide the Temporary Insurance Receipt TIR-2015-KS to customer and submit a copy of the receipt with the application and payment. The receipt must be signed by the agent.

Split Commissions - Split commissions are allowed between 2 agents. Check off Agent Split near the upper right hand corner of the application. Information regarding the secondary agent should be provided in the designated area on the Producer Certification.

(CA Only) Fraud Notice - The fraud notice is required to be presented to the person who applies for a policy. A copy should be kept on file (Do Not send to Gerber Life).

(CA Only) Disclosure to Seniors – If individual is age 65 or older and agent is meeting in their home, provide completed form to individual. A copy should be kept on file (Do Not send to Gerber Life).

(NY Only) Definition of Replacement – Replacements are not allowed in New York, although the Definition of Replacement form must be filled out for all life insurance applications. The document must be signed by the Applicant and the Agent, and a copy left with the Applicant. This document must be returned to the Company with the application. The signed date on the form must be the same signed date as the application.

(NY Only) Agent Best Interest Certification – In compliance with NY Regulation 187, it is required that agents act in their customers best interest. This form is a certification that the product selected is in the best interest of the customer. This form must be signed and submitted with all NY applications. Failure to comply will result in the application being closed out.

(NY Only) Producer Checklist – In compliance with NY Regulation 187, agents are required to retain documentation related to recommendations made to a customer regarding life insurance products. This form is for your records only and is not to be submitted with applications.

(NY Only) Life Suitability and Best Interest Questionnaire – In compliance with NY Regulation 187, agents are required to determine the suitability of a product(s), prior to making a recommendation to the customer. This questionnaire is required to establish product suitability in accordance with the NY Regulation 187. One form is required per policy and is owner specific *(you cannot list multiple insureds on one questionnaire.)* This form is required to be completed in full and failure to comply will result in the application being closed out.

• Please follow your Marketing Office procedures for application submission to Gerber Life.

[1]*Replacements are not accepted in following states: CA, DE, FL, ID, IL, KY, MA, NY, PA, PR, TN, and WA*

Gerber Life Insurance

445 State Street • Fremont, Michigan 49412
www.gerberlife.com

Agency Application

Agent Name_____ **Agency Name**_____ **Agent #**_____

Agent Phone #_____ **Agent Email** _____ ☐ **Agent Split**

Application for: Individual Whole Life Insurance **Gerber Life Insurance Company White Plains, NY 10605** **Must be age 50-80 to qualify**

COVERAGE APPLIED FOR: Whole Life: Face Amount Applied For (must be from $25,000-$100,000)
❑ **$25,000** ❑ **$50,000** ❑ **$75,000** ❑ **$100,000** ❑ **Other $_____,000**

YOUR INFORMATION: (Give full legal name)

First Name _____ MI _____ Last Name _____ Gender _____

Date of Birth _____ (MM/DD/YYYY) Place of Birth (State/Country) _____ Social Security Number _____-_____-_____

Driver's License ☐ **Yes** ☐ **No** Number_____State Issued _____ If **no** License, reason ☐ did not renew ☐ never issued ☐ revoked/suspended

Address_____City _____State_____Zip_____

Email _____ Phone ( )_____Cell: ☐ **Yes** ☐ **No**

Are you a United States citizen or do you have Permanent Legal Resident (Green Card) status? ☐ **Yes** ☐ **No**

Are you actively employed? ☐ **Yes** ☐ **No**

If **no**, are you a. ☐ **Full-time student** ☐ **Retired** ☐ **Stay at home parent** ☐ **Other**

In the past 24 months, have you smoked or used tobacco in any form? ☐ **Yes** ☐ **No** Height_____ft._____in. Weight_____lbs.

MEDICAL AND BACKGROUND QUESTIONS:

1. In the past 10 Years, have you been diagnosed, treated, hospitalized or prescribed medication by a medical professional for:

Cancer or Tumor?	☐ **Yes** ☐ **No**	Alzheimer's or Dementia?	☐ **Yes** ☐ **No**
Diabetes?	☐ **Yes** ☐ **No**	Other Mental Disorder	☐ **Yes** ☐ **No**
Drug or Alcohol Abuse?	☐ **Yes** ☐ **No**	AIDS (Acquired Immune Deficiency Syndrome)?	☐ **Yes** ☐ **No**
Heart Disease or Disorder?	☐ **Yes** ☐ **No**	HIV (Human Immunodeficiency Virus) Infection?	☐ **Yes** ☐ **No**
Central Nervous System Disease or Disorder?	☐ **Yes** ☐ **No**	Emphysema or COPD?	☐ **Yes** ☐ **No**
Stroke or TIA?	☐ **Yes** ☐ **No**	Other Chronic Lung Disease or Disorder?	☐ **Yes** ☐ **No**

2. Other than noted in question 1 above, and excluding pregnancy, in the past 5 years have you been advised by a medical professional of any other medical condition that will require additional tests (excluding those related to HIV), treatment or surgery? ☐ **Yes** ☐ **No**

3. In the past 5 years have you been convicted of a felony or misdemeanor, or are you currently on parole or probation, do you have charges pending against you or are you currently incarcerated? ☐ **Yes** ☐ **No**

4. In the past year, have you received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ **Yes** ☐ **No**

Give details for all "Yes" answers to questions 1-4. Use and sign separate page if necessary.

Details	Dates of diagnosis or offense	Date last treated or last offense	Name & Address of Doctor or Facility

OWNERSHIP:

Will you own this policy? ☐ **Yes** ☐ **No**

BENEFICIARY INFORMATION:

Primary Beneficiary(ies)_____Relationship to the Insured_____

OTHER COVERAGE:

Have you applied for any life insurance or annuities in the past 12 months, have any life insurance in force, or is any application for life insurance or reinstatement now pending? ☐ **Yes** ☐ **No**

If "Yes", please complete below.

Company Name_____City, State _____Face Amount_____Month/Year Issued_____

Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application? ☐ **Yes** ☐ **No**

SHFA-17

(continues on back)

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any insurance company, employer, physician, medical professional, hospital, medical facility, pharmacy, pharmacy benefit manager, consumer reporting agency, including motor vehicle driving records, MIB, Inc. (MIB), or any other person or organization that has any record of information about me to give to Gerber Life Insurance Company, its reinsurers or its authorized representatives, (together, the Company) information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including drug and alcohol treatment information, prescription history records, or other information the Company requires to determine insurability, eligibility for benefits, investigate claims, or support the business operations of the Company related thereto. I authorize Gerber Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB. I further authorize the sources listed above except MIB to give such information to a consumer reporting agency acting on behalf of Gerber Life Insurance Company. Gerber Life Insurance Company may release information obtained by this Authorization to its reinsurers, to MIB, to other insurers with whom I have policies or to whom I may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me, or as may otherwise be lawfully required.

My authorized representative or I may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed or until any other time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health or other privacy related information from the Company from re-disclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I understand that a copy of this Authorization will be provided, upon request, to me or a person authorized on my behalf. I understand that disclosure of information to the Company may subject the information to re-disclosure in accordance with the Company's privacy policy and MIB rules. Any such re-disclosed information may no longer be protected by federal rules governing privacy and confidentiality. This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Gerber Life Insurance Company at the address above.

It is understood and agreed that: All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Other than as stated in any conditional receipt, any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application between the time of application and delivery of the policy.

X Your Signature _____ Date_____

X Signature of Policyowner (if other than you)_____ Date_____

Signed at (City, State)_____

SHFA-17

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber 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. If you question the accuracy of the 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.

Gerber 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.

MIB-14

Your Rights under the Fair Credit Reporting Act

Depending on the size of the policy applied for, we may request that an investigative consumer report about the Proposed Insured be given to us. It will be conducted by a national organization skilled in obtaining information about people. A credit report may be requested in connection with this application to determine eligibility of insurance or premium to be charged.

The kind of information we may be seeking includes such facts as residence verification, marital status, occupation, general reputation, personal characteristics and mode of living. It will be obtained through personal interviews with the Proposed Insured's friends, neighbors, associates and other acquaintances. Inquiries will not be directed toward determining the Proposed Insured's sexual orientation.

The Proposed Insured, upon written request, will be informed whether or not an investigative report was requested, and if a report was ordered, the name and address of the Consumer reporting agency. A copy of this report is available to the Proposed Insured upon request.

Notice of Information Practices/Privacy Statement

The following notice applies to applicants in the states of AZ, CA, CT, GA, IL, ME, MA, MN, MT, NJ, NV, NC, OH, OR and VA: To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

Benefits, Exclusions and Limitations

Approval is based on answers to health questions and the information obtained as a result of the underwriting associated with the application review. Medical exams are required for applicants age 71 and over. If the insured dies by suicide within two years from the issue date (one year in ND), the only amount payable will be the premiums paid for the policy, less any debt against the policy.

Benefit amounts are subject to Gerber Life insurance limits.

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Policy Form Series GLWL-19

Accelerated Death Benefit Rider Series ADB-11-WL

To contact us using a Video Relay Service, please call 1-800-285-7701.

Gerber Life Insurance
445 State Street • Fremont, Michigan 49412
www.gerberlife.com

Agency Application

Applicant's Name_____

PRODUCER CERTIFICATION Must be Completed by Producer if applicable

To the best of your knowledge,

1. Does the Proposed Insured have any life insurance or annuities in force or is any application for life insurance or reinstatement now pending? (If Yes, complete appropriate replacement forms)..... ☐ **Yes** ☐ **No**
2. Will the coverage applied for replace any life insurance or annuity coverage now in force or pending on the life of the Proposed Insured? (If Yes, complete appropriate replacement forms)..... ☐ **Yes** ☐ **No**

Is this a 1035 Exchange? ..... ☐ **Yes** ☐ **No**

Is this an internal term conversion? ..... ☐ **Yes** ☐ **No**

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein ..... ☐ **Yes** ☐ **No**

Agent ID_____ Date_____

X Signature of Licensed Agent_____ Printed Name of Licensed Agent_____

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The "Insurability of any Person proposed for Insurance" statement above refers to the responses on the application and not the health of the proposed insured.

- By answering 'YES' to the "I certify" statement above, the application CAN be processed. You are indicating that you have no knowledge of anything that could affect the insurability (responses on the application) of the proposed insured.
- By answering 'NO' to the "I certify" statement above, the application CANNOT be processed. You are indicating that you have knowledge that could affect the insurability (responses to questions) of the proposed insured.

Please provide secondary agent information for split commissions:

First Name: _____ Last Name: _____

Gerber Life Agent ID: _____ (if agent ID is not known, write in 9999-9999) Percent of Split: _____%

Please review the following outline of requirements:

✓ This form must be sent in at time of application in order for a split commission to be applied.

✓ Split Commissions are allowed only between two agents.

✓ The name, agent ID, and split percentage for the secondary agent must be included in the request.

– If the percentage of the split is missing, it will default to 50% for each agent for the life of the policy.

GERBER LIFE INSURANCE COMPANY
1311 Mamaroneck Avenue
White Plains, New York 10605

DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT PAYMENT OPTION

GENERAL DESCRIPTION OF THE ACCELERATED DEATH BENEFIT

The Accelerated Benefit Payment Option allows the Owner of the Policy to receive an accelerated benefit if the Insured's life expectancy is 12 months or less.

The Owner may make only one request for an Accelerated Death Benefit payment. The Owner may request an Accelerated Death Benefit payment of up to 50% of the Death Benefit. The minimum Accelerated Death Benefit payment the Company will pay is 10% of the Death Benefit or $10,000 whichever is greater. Notwithstanding these minimum and maximum limits, if the Death Benefit payable under the Policy is less than $20,000, you may accelerate the lesser of $10,000 or 100% of the Death Benefit. The Accelerated Death Benefit will be paid as a lump sum.

Request for an Accelerated Death Benefit payment must be in writing and the Company must receive the request while the Policy is in force. The Company must receive written approval by any irrevocable beneficiary under the Policy and a full release of any assignment of the Policy as collateral.

TAX CONSEQUENCES OF RECEIVING AN ACCELERATED DEATH BENEFIT PAYMENT

Depending on a number of factors, an Accelerated Death Benefit payment may be considered taxable income. The Owner should seek assistance from a qualified tax advisor before requesting an Accelerated Death Benefit.

COSTS OF THE ACCELERATED DEATH BENEFIT PAYMENT

There is no premium or cost of insurance for the Option. However, the Company will add an administrative fee not exceeding $250 to the Accelerated Death Benefit at the time of payment. The Company will charge interest on the Accelerated Death Benefit payment. Interest will accrue on the amount of the Accelerated Death Benefit at the lesser of the current yield on 90-day United States Treasury bills or Policy Loan interest rate.

EFFECT OF ACCELERATED BENEFIT PAYMENT

The Accelerated Death Benefit payment, the administrative fee and any accrued interest will be a lien against the Policy. The total amount of the lien outstanding will reduce the amount otherwise available under the Policy's Death Benefit and Net Cash Value. The Net Cash Value is the amount available upon surrender of the Policy and available for policy loans.

If premiums are required to be paid under the Policy, they will remain payable and will not be reduced or eliminated as a result of an Accelerated Death Benefit payment.

No later than the time the benefit payment is made, We will provide You with a written notice showing the dollar amount of the payment and the remaining available amount of death benefit and Net Cash Value, if any.

ACKNOWLEDGMENT

I, the undersigned Insured (and Owner if other than the Insured), acknowledge that I have read and received this Disclosure Statement for Accelerated Death Benefit Option at the time of application for the Policy.

_____	_____	_____	_____
Proposed Insured's Signature	Date	Owner's Signature (if other than Insured)	Date
		_____	_____
		Agent or Broker's Signature	Date

SAMPLE ILLUSTRATION

The sample illustration below shows the effect of an Accelerated Death Benefit payment. The sample assumes a policy in the sixteenth (16th) policy year with a: 1) $100,000 death benefit; 2) $20,000 Cash Value, and 3) no outstanding Indebtedness. It also assumes the owner has requested the maximum accelerated benefit amount and an administrative fee of $250. The lien interest rate at the time of calculation is 5%.

Before Accelerated Death Benefit Payment

Death Benefit	$ 100,000
	x 50%
Maximum Accelerated Death Benefit Available	$ 50,000

Immediately After Accelerated Death Benefit Payment

Amount of Accelerated Benefit Payment (Lien Amount)	$ 50,000
less: Administrative Fee	$ 250
Amount Paid	$ 49,750
Death Benefit	$ 100,000
less: Lien Amount	$ 50,000
Death Proceeds Payable at Insured's Death	$ 50,000
Net Cash Value	$ 20,000
less: Lien Amount	$ 50,000
Remaining Net Cash Value	$ 0

One Year After Accelerated Death Benefit Payment

Amount of Accelerated Benefit Payment	$ 49,750
plus: Administrative Fee	$ 250
plus: Accrued Lien Interest *	$ 2,500
Lien Amount	$ 52,500
Death Benefit	$ 100,000
less: Lien Amount	$ 52,500
Death Proceeds Payable at Insured's Death	$ 47,500
Net Cash Value Before Accelerated Death Benefit Payment	$ 23,000
Less: Lien Amount	$ 52,500
Net Cash Value	$ 0

* Important Notice: Interest begins at payment and will increase the amount of the Indebtedness over time.

GERBER LIFE INSURANCE COMPANY
1311 Mamaroneck Avenue
White Plains, NY 10605
800-253-3074

IMPORTANT NOTICE REGARDING REPLACEMENTS

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, otherwise terminated, or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. Financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer any questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

   ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature and Printed Name Date

_____ _____

Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older -- are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

SUPPLEMENT TO AN APPLICATION
FOR INDIVIDUAL LIFE INSURANCE POLICY

Gerber Life Insurance Company
[1311 Mamaroneck Avenue]
[White Plains, NY 10605]

This form is a supplement to the application for an Individual Life Insurance policy on the following proposed insured:

First Name:_____ Middle Initial:_____ Last Name:_____

The owner of the Individual Life Insurance policy is to be:

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____Email:_____ Phone:_____ Cell: ❑ Yes ❑ No

What is the owner's relationship to the insured?_____

It is understood and agreed that:

All statements and answers made in all parts of the application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued shall not take effect until it is approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

Owner's Signature:_____ Date:_____

ALSUPP-14

Name of Proposed Insured:_____ **Application number:**_____

GERBER LIFE INSURANCE COMPANY

Authorization to Obtain, Use, and Disclose Personal Information (Insurance Eligibility)

PURPOSES

This authorization applies to any Personal Information (defined below) that may be obtained, used, or disclosed about the Proposed Insured by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

PERSONAL INFORMATION

I understand and agree that the types of "Personal Information" that may be obtained, used, or disclosed about the Proposed Insured on the basis of this authorization may include, to the extent permitted by law:

(i) any and all health records about the Proposed Insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,

(ii) non-health information about the Proposed Insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

AUTHORIZATION FOR OTHERS TO DISCLOSE TO US

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the Medical Information Bureau (MIB); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of Personal Information about the Proposed Insured does not apply to this authorization.**

AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

FAILURE TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

DURATION AND REVOCATION

Unless revoked earlier, this authorization will remain in effect for 24 months* from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company
ATTN: Underwriting Department
445 State Street
Fremont, MI 49412

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

COPIES OF THIS FORM

I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured. I also understand that I am entitled to obtain a copy of this authorization form.

_____ _____
Date Signature of Proposed Insured or Authorized Representative

_____
Relationship to Proposed Insured

*For residents in the state of Minnesota, unless revoked earlier, this authorization will remain in effect for 12 months from the date signed.

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

REPLACEMENT

SALES/MARKETING FORMS

APPLICANT NAME: _____

APPLICATION STATE: _____

AGENT NAME: _____

AGENT#: _____ **AGENCY:** _____ **DATE:** _____

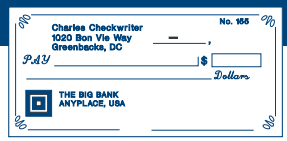
In compliance with NAIC Model Replacement Act, listed below are the Marketing/Sales forms used in the sale of this application:

Please use full Gerber Life Form# shown at the bottom of the Marketing/Sales material

Form # _____
Form # _____
Form # _____
Form # _____
None _____

Gerber Life will not charge your account any money until 1-3 days after your application is approved.

How to pay your premiums automatically through your CHECKING ACCOUNT:



1. Complete and sign the Authorization Form below.
2. Please provide the required financial information. Contact your financial institution for the correct account and routing numbers.
3. Your first premium will be charged 1-3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
4. Premiums will continue to be automatically withdrawn each month unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on this Form.

How to pay your premiums automatically through MASTERCARD or VISA:

1. Complete and sign the Credit Card Authorization Form below.
2. Your first premium will be charged 1-3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
3. Premiums will continue to be charged monthly to the credit card you select, unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on the Form.

Questions? Call our toll-free number: **1-800-428-4947** Monday-Friday, 8:30am to 6pm (EST)

Use this Authorization Form for payment by automatic withdrawal from CHECKING ACCOUNT

☐ **Yes,** I hereby authorize the bank or financial institution named below to pay my insurance premiums as indicated below, by automatic withdrawal from my checking account. **I understand that my 1st premium will not be withdrawn until 1-3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____

Insured's name: _____ **Date of Birth:** _____

Name of Financial Institution _____

Type of Account: ☐ **Checking** ☐ **Savings** **Bank Transit #** _____ **Account #** _____

X _____ **Date** _____
(Accountholder's Signature)

Preferred Payment Date _____

If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age. Payment date must be within 28 days of submission

Please automatically withdraw my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

Use this Credit Card Authorization Form for payment by MASTERCARD or VISA

☐ **Yes,** please charge my premiums to my credit card account. **I understand that my 1st premium will not be withdrawn until 1-3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Please check ☑one: ☐ **Mastercard – Must contain 16 numbers** ☐ **VISA – Must contain 13 or 16 numbers**

Card Number: _____ **Exp. Date** _____

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____

Insured's Name: _____ **Date of Birth:** _____

X _____ **Date** _____
(Cardholder's Signature)

Preferred Payment Date _____

If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age. Payment date must be within 28 days of submission

Please charge my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

GERBER LIFE INSURANCE COMPANY • Home Office: 1311 Mamaroneck Avenue, Suite 350, White Plains, NY 10605

CONDITIONAL RECEIPT FOR UNDERWRITTEN POLICIES

THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. PAYMENT IN CASH IS NOT ACCEPTABLE.

All checks and money orders must be made payable to: GERBER LIFE INSURANCE COMPANY.

Any insurance under this Conditional Receipt will be effective from the date of the completed application, or the date of the last medical examination required by the Company's established rules, whichever is later, provided that all of the following conditions have been fulfilled:

1. The first premium is paid by the date of the completed application by check or money order that is honored and collectable; and

2. On the date of the completed application or the date of the last medical examination, if required, whichever is later, the proposed insured is insurable and acceptable for the insurance, exactly as applied for, as determined by Gerber Life Insurance Company, under its underwriting rules and practices for the plan and amount of insurance applied for and at the Company's standard premium rate.

The amount of any insurance effective under this Conditional Receipt is limited to the lesser of the amount applied for in the application or $25,000.

Any insurance under this Conditional Receipt ends at the earlier of 1) sixty (60) days from the date of the completed application, or 2) the date the policy is approved, which is the Policy Date.

If the conditions under this Conditional Receipt are not satisfied, no insurance of any kind will be in effect and the payment will be returned to the applicant.

THIS CONDITIONAL RECEIPT DOES NOT PROVIDE ANY TEMPORARY OR INTERIM INSURANCE COVERAGE.

Received from _____ the sum of $_____ paid by check or money order at the time of signing the insurance application.

The proposed insured is: _____

Date _____ Signature _____ Agent# _____
Month /Date/ Year Licensed Agent

Date _____ Signature _____
Month /Date/ Year Proposed Insured

CRUW-2011

Agent Instructions:

PLEASE NOTE THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT AND A COPY MUST BE SENT TO GERBER LIFE INSURANCE WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. THIS MUST BE DONE AT THE TIME OF APPLICATION. ADDITIONALLY, THE CONDITIONAL RECEIPT, APPLICATION AND THE CHECK MUST ALL HAVE THE SAME DATE.