

SERFF Tracking Number: UNAM-127375528 State: Arkansas
Filing Company: Constitution Life Insurance Company State Tracking Number: 49589
Company Tracking Number: CL-MP-11-APP-AR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Multi Product Application
Project Name/Number: /

Filing at a Glance

Company: Constitution Life Insurance Company

Product Name: Multi Product Application

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UNAM-127375528 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49589

Co Tr Num: CL-MP-11-APP-AR

State Status: Approved-Closed

Author: Holly Parenti

Reviewer(s): Rosalind Minor

Date Submitted: 08/18/2011

Disposition Date: 08/19/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/19/2011

State Status Changed: 08/19/2011

Created By: Holly Parenti

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Holly Parenti

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Information Application Submission

Form:

CL-MP-11-APP-AR Application

Dear Sir or Madam:

This is an informational filing. This application was filed and approved with your department under SERFF #UNAM-

SERFF Tracking Number: UNAM-127375528 State: Arkansas
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127335959 approved on August 2, 2011. This application has not been printed or put into use.

We have made a change to the application. We have replaced "Senior Tribute Life Insurance" with "Whole Life Insurance" in 4 places within the application. On the top of the first page and in the black headers on page 1, 4 and 6. This is the only change made to the application.

We certify that these forms comply with the provisions of 19ss 10B and all applicable requirements of the Department.

We have bracketed office addresses and telephone numbers on all of the forms so that they may be changed without re-filing.

If additional information is needed, please contact me at 800-538-1053 ext. 4104522 or hparenti@uafc.com

Company and Contact

Filing Contact Information

Holly Parenti, hparenti@uafc.com
 P.O. Box 958465 407-628-1776 [Phone] 8531 [Ext]
 Lake Mary, FL 32795-8465

Filing Company Information

| | | |
|-------------------------------------|-------------------------|--------------------------|
| Constitution Life Insurance Company | CoCode: 62359 | State of Domicile: Texas |
| 1001 Heathrow Park Lane | Group Code: 953 | Company Type: |
| Suite 5001 | Group Name: | State ID Number: |
| Lake Mary, FL 32746 | FEIN Number: 36-1824600 | |
| (407) 995-8000 ext. [Phone] | | |

Filing Fees

| | |
|------------------|-------------------------|
| Fee Required? | Yes |
| Fee Amount: | \$50.00 |
| Retaliatory? | No |
| Fee Explanation: | \$50.00 for application |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|-------------------------------------|---------|----------------|---------------|
| Constitution Life Insurance Company | \$50.00 | 08/18/2011 | 50733767 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 08/19/2011 | 08/19/2011 |

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TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: Multi Product Application
Project Name/Number: /

Disposition

Disposition Date: 08/19/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UNAM-127375528 *State:* Arkansas
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TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|----------------------------|----------------------------------|-----------------------------|----------------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Health - Actuarial Justification | Approved-Closed | Yes |
| Supporting Document | Outline of Coverage | Approved-Closed | Yes |
| Supporting Document | PPACA Uniform Compliance Summary | Approved-Closed | Yes |
| Form | Multi product Application | Approved-Closed | Yes |

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 Company Tracking Number: CL-MP-11-APP-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Multi Product Application
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Form Schedule

Lead Form Number: CL-MP-11-APP-AR

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------------------------|---------------------|------------------------------------|------------------------------|---------|----------------------|-------------|-------------------------|
| Approved- Closed 08/19/2011 | CL-MP-11- APP-AR | Application/ Enrollment Form | Multi product Application | Initial | | | CL-MP-11- APP-AR.pdf |

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Houston, Texas Administrative Office: PO Box 13547; Pensacola, FL 32591-3547 · (800) 789-6364

APPLICATION FOR:

- | | |
|---|--|
| <input type="checkbox"/> First Diagnosis of Cancer Insurance <input type="checkbox"/> Hospital Indemnity Insurance | <input type="checkbox"/> Whole Life Insurance <input type="checkbox"/> Supplemental Senior Dental Insurance |
|---|--|

APPLICATION DATE

____/____/____
MM DD YYYY

REQUESTED EFFECTIVE DATE

____/____/____
MM DD YYYY

POLICYHOLDER

New Current Reinstatement
 Policy No. _____

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

| | | |
|----------------------|---------------------------------|--------------------------|
| Mgr./Commission Code | District Sales Manager/Marketer | Application Reviewed By: |
|----------------------|---------------------------------|--------------------------|

Mail Policy To: Insured Agent

APPLICANT INFORMATION

APPLICANT TO BE INSURED

| | | | | | |
|--|----------------|---------------------------------------|-------------------------------|---------------------------------|---------------|
| Name (First/Middle/Last) | | | Social Security Number | | |
| Address (Street / Rural Route) | | | | | |
| City | County | State | Zip | | |
| Birthdate (MM/DD/YYYY) | State of Birth | Age | Male <input type="checkbox"/> | Female <input type="checkbox"/> | |
| Home Phone (_____) _____ Area Code | | Cell Phone (_____) _____ Area Code | | | |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single | | Occupation: _____ | | Height: _____ | Weight: _____ |

SPOUSE TO BE INSURED

| | | | | | |
|---|----------------|-----|-------------------------------|---------------------------------|--|
| Name (First/Middle/Last) | | | Social Security Number | | |
| Birthdate (MM/DD/YYYY) | State of Birth | Age | Male <input type="checkbox"/> | Female <input type="checkbox"/> | |
| Hospital Indemnity Only (Insured Spouse) Beneficiary: _____ | | | Relationship: _____ | | |

CHILD(REN) TO BE INSURED (PRINT FIRST NAME, MI, LAST NAME)

| First | Middle | Last | Gender | Age | Date of Birth | | | State of Birth |
|-------|--------|------|--------|-----|---------------|-----|------|----------------|
| | | | | | Month | Day | Year | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

For additional children, please attach a separate piece of paper, signed by the proposed insured and including all of the above information for each child.

IF OWNER IS NOT PROPOSED INSURED FOR ANY PRODUCT, COMPLETE THE FOLLOWING:

| | |
|---------------------------------|-------------------------------------|
| Owner: | Relationship: |
| Birthdate (MM/DD/YYYY): | Social Security / Tax ID Number: |
| Address (Street / Rural Route): | City: _____ State: _____ Zip: _____ |

IF APPLYING FOR WHOLE LIFE INSURANCE OR HOSPITAL INDEMNITY INSURANCE, PROPOSED INSURED SHOULD PROVIDE THE FOLLOWING BENEFICIARY INFORMATION:

Primary Beneficiary of the Proposed Insured (indicate percentages if split):

| | |
|---------------|-------------------------|
| Relationship: | Birthdate (MM/DD/YYYY): |
|---------------|-------------------------|

Contingent Beneficiary of the Proposed Insured (indicate percentages if split):

| | |
|---------------|-------------------------|
| Relationship: | Birthdate (MM/DD/YYYY): |
|---------------|-------------------------|

IF APPLYING FOR FIRST DIAGNOSIS OF CANCER INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | Proposed Insured | | Spouse | | Child(ren) | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| 1. In the past 5 years has any person to be insured been hospitalized, treated or been advised by a Medical Professional/Doctor, to have diagnostic procedures and/or follow up for: | | | | | | |
| a. Cancer, Malignancy, Leukemia, Melanoma, Lymphoma, Hodgkin's disease?..... (If "yes," please provide details below.) | | | | | | |
| | <input type="checkbox"/> |
| b. Elevated PSA tests, abnormal pap test or mammogram, tumors, growths, bleeding moles or blood in the stool?..... (If "yes," please provide details below.) | | | | | | |
| | <input type="checkbox"/> |

| Name of Person | Details |
|----------------|---------|
| | |
| | |
| | |

| | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. In the past 10 years has any person to be insured been diagnosed as having, or treated by or advised to be treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); Aids Related Complex (ARC); or tested positive for exposure to the Human Immunodeficiency Virus (HIV)?..... (If answered "yes," that person will not be eligible for coverage.) | | | | | | |
| | <input type="checkbox"/> |
| 3. Tobacco Use Information: To be completed by all Applicants Does any person to be insured now use or have they used tobacco products in any form within the last 12 months?..... (If "yes" complete information below.) | | | | | | |
| | <input type="checkbox"/> |

| Name of Person | Type | Frequency |
|----------------|------|-----------|
| | | |
| | | |

| 4. Is this coverage replacing any health insurance in this or any other company?... (If "yes" complete information below.) | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> |
| Company Name and Address | Policy No. | Type of Coverage | Effective Date | Benefits | | |
| | | | | | | |

MAXIMUM COVERAGE AVAILABLE IS \$50,000 FOR ALL COVERAGES IN FORCE

| 5. Does any person to be insured have any First Diagnosis of Cancer lump sum coverage currently in force with this Company or any other company?..... (If "yes," complete the following.) | | | | | | |
|---|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Name of Person | Company | Policy Description/Form No. | Amount of Coverage | | | |
| | | | \$ | | | |
| | | | \$ | | | |
| | | | \$ | | | |

IF APPLYING FOR LIMITED BENEFIT HOSPITAL INDEMNITY INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | Proposed Insured | | Spouse | | Child(ren) | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| 1. Are you currently bedridden, confined to a wheelchair, in a hospital or nursing home, receiving home health care or been hospitalized 3 or more times in the past 2 years?..... | <input type="checkbox"/> |
| 2. Within the past 5 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) or have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?... | <input type="checkbox"/> |
| 3. Within the past 2 years have you had, been advised you may have, been diagnosed or treated by a medical professional for Alzheimer's disease, senile dementia, organic brain disease?..... | <input type="checkbox"/> |
| 4. Within the past 12 months have you had, been advised you may have, been diagnosed or treated by a medical professional for: | | | | | | |
| a. Diabetes requiring insulin, kidney disease, cirrhosis of the liver, Hepatitis C?... | <input type="checkbox"/> |
| b. Cancer (other than skin basal cell), Leukemia, Hodgkin's disease, Lymphoma or Melanoma?..... | <input type="checkbox"/> |
| c. Congestive heart failure, stroke (CVA), heart attack or any other heart or circulatory disorder requiring surgery?..... | <input type="checkbox"/> |
| d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other respiratory disorder?..... | <input type="checkbox"/> |
| 5. Have you been advised during the past year to have surgery for joint disorder or replacements, or for any heart or circulatory condition that has not been performed?..... | <input type="checkbox"/> |

(If answered "yes" to any of questions 1 - 5 above, the applicant is not eligible for coverage.)

| | Proposed Insured | | Spouse | | Child(ren) | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| Is this coverage replacing any health insurance in this or any other company?..... | <input type="checkbox"/> |

If "Yes," give details below:

| Name of Person | Company Name and Address | Policy Number | Type of Coverage | Effective Date | Benefits |
|----------------|--------------------------|---------------|------------------|----------------|----------|
| | | | | | |
| | | | | | |
| | | | | | |

Does any person to be insured have any hospital confinement coverage currently in force with this Company or any other company?
 Yes No

If yes, complete the following:

| Name of Person | Company | Policy Description / Form No. | Amount of Coverage |
|----------------|---------|-------------------------------|--------------------|
| | | | \$ |
| | | | \$ |
| | | | \$ |

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

Does the applicant own existing, in-force policies or contracts on the Proposed Insured? Yes No
 If "Yes," complete details the required replaced form.

Do you now or have you within the last year used tobacco products in any form? Yes No
 If "Yes," please explain:

If applicant answers "Yes" to any question in this section, the Proposed Insured is not eligible for coverage.

1. Is the Proposed Insured currently:
 - a. hospitalized, bedridden, confined to a nursing facility, receiving hospice care, confined to a wheel chair due to disease, or received or awaiting an organ transplant?..... Yes No
 - b. diagnosed with or being treated for a terminal illness?..... Yes No
2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for Alzheimer's Disease, Dementia, Memory loss, ALS (Lou Gehrig's Disease)?..... Yes No
3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for, or been advised by a physician they may have:
 - a. Congestive Heart Failure?..... Yes No
 - b. Cancer, Malignancy, Leukemia, Melanoma, Lymphoma, Hodgkin's disease?..... Yes No
5. In the past 12 months, has the Proposed Insured had been diagnosed with, treated for or been advised by a physician to be treated for:
 - a. Heart Attack, Angina (chest pain), Angioplasty, Heart Surgery, Stent Placement, Stroke or Aneurysm?..... Yes No
 - b. Kidney Dialysis, Alcohol or Drug Abuse/Dependency ?..... Yes No
6. In the past 24 months has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
 - a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Pulmonary fibrosis, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder?..... Yes No
 - b) Parkinson's Disease, Muscular Dystrophy, Kidney Disease/Kidney Failure, Cirrhosis, or other Liver Disease, Sickle Cell Anemia?..... Yes No
7. In the past 24 months, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for:
 - a) Heart Attack, Angina (chest pain), Pacemaker/Defibrillator placement, Heart Surgery, Stroke, Aneurysm or other Heart or Circulatory disorder?..... Yes No
 - b) Alcohol or Drug Abuse/Dependency?..... Yes No
 - c) Diabetes requiring insulin or Diabetic Coma?..... Yes No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder?..... Yes No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing?..... Yes No

Special Requests:

Home Office Use Only:

TO BE COMPLETED BY ALL APPLICANTS

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my insurance will be effective on the date it is issued by the company, except as stated in the Conditional Receipt. I personally completed the above questions. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this insurance.**

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Pharmaceutical Database, or other organization, institution or person, that has records or knowledge of me or any other family member applying for insurance to give to Constitution Life Insurance Company, or its reinsurers, any such information including, but not limited to physical and mental conditions, including psychiatric treatment and/or drug and/or alcohol abuse and/or HIV/AIDS related records. This authorization shall be valid for a period of thirty (30) months from the date signed. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Company's Administrative Office. If this authorization was obtained as a condition of obtaining insurance coverage, my right to revoke is also subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

I AGREE THAT: 1. All answers in this application (a) are true and complete to the best of my knowledge; and (b) will be relied on to determine insurability. 2. If the minimum premium is paid on the date the application is signed, the policy(ies) and rider(s) applied for will be in effect from that date, subject to: (a) underwriting requirements; (b) the terms of the attached receipt; (c) the terms of the policy(ies) and rider(s); and (d) Constitution Life's right to rescind the policy(ies). A minimum premium is an amount equal to the full premium for the mode chosen on the application on the policy(ies) applied for. 3. If the minimum premium is not paid as provided, then no insurance will be in effect unless; (a) during the lifetime of the person proposed for insurance, a policy or rider is delivered and accepted and the entire first premium is paid; and (b) at the time of either delivery and acceptance or payment, whichever is later, all answers in this application are still true and complete to the best of my knowledge. 4. The agent is not authorized to waive the terms of the receipt.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge that all persons to be covered under this policy (or these policies) are not covered also by any Title XIX program (Medicaid, MediCal or any similar name. I acknowledge receiving: (1) An Outline of Coverage (Cancer, Hospital Indemnity and Dental); and (2) "A Guide to Health Insurance for People With Medicare" (For applicants eligible for Medicare).

Application Signed in: _____
City State Date

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank.

TO BE COMPLETED BY ALL APPLICANTS

Amount Paid with Application \$ _____

Dated at _____, this _____ day of _____, _____.

| | | |
|---|--|---|
| _____ Signature of Owner (if other than Proposed Insured) | _____ Signature of Proposed Insured | _____ Signature of Spouse (if insured) |
|---|--|---|

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

Do you have any knowledge or reason to believe that replacement of existing health insurance may be involved? Yes No

| | | |
|-----------------------------|--------------------------------------|------------------------|
| _____ Agent Printed Name | _____ Signature of Licensed Agent | _____% Agent Number |
| _____ Agent Printed Name | _____ Signature of Licensed Agent | _____% Agent Number |

IF APPLYING FOR SENIOR DENTAL INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | | |
|----------------------|---|---|---|
| Plan Deductible: \$0 | Annual Benefit Maximum <input type="checkbox"/> Enhanced (\$6000) <input type="checkbox"/> Standard (\$1500) | A) TOTAL MONTHLY PAC PREMIUM: \$ _____ | E) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |
|----------------------|---|---|---|

IF APPLYING FOR FIRST DIAGNOSIS OF CANCER INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | |
|---|---|---|
| BENEFIT | BENEFIT AMOUNT | MONTHLY PAC PREMIUM |
| First Diagnosis of Cancer Policy Benefit Amount – Proposed Insured | \$ _____ | \$ _____ |
| OPTIONAL RIDER BENEFITS | | |
| <input type="checkbox"/> Spouse First Diagnosis of Cancer Rider Benefit Amount | \$ _____ | \$ _____ |
| <input type="checkbox"/> Child’s First Diagnosis of Cancer Rider Benefit Amount | \$ _____ | \$ _____ |
| | B) TOTAL MONTHLY PAC PREMIUM: \$ _____ | F) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |

IF APPLYING FOR HOSPITAL INDEMNITY INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| POLICY BENEFIT | <input type="checkbox"/> Proposed Insured | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child(ren) |
| Daily Hospital Confinement Indemnity Benefit | \$ _____ Daily Benefit | Daily Benefit 100% of Proposed Insured’s Benefit | Daily Benefit (50% of Proposed Insured’s Benefit) |
| OPTIONAL RIDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump Sum Hospital Confinement Indemnity Benefit | \$ _____ Lump Sum Benefit | Lump Sum Benefit 100% of Proposed Insured’s Benefit | Lump Sum Benefit (50% of Proposed Insured’s Benefit) |
| Durable Medical Equipment Benefit | <input type="checkbox"/> 30% of \$1000 charges per year | <input type="checkbox"/> 30% of \$1000 charges per year | <input type="checkbox"/> 30% of \$1000 charges per year |
| Ambulance Benefit per confinement | <input type="checkbox"/> \$200 per trip | <input type="checkbox"/> \$200 per trip | <input type="checkbox"/> \$200 per trip |
| Accidental Death and Dismemberment Benefit <i>Choose Benefit Level – Principal Sum</i> | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 |
| Other _____ | | | |

| | | | | |
|-----------------------------------|-------------------------|--------------------------------------|---|---|
| | Proposed Insured | Proposed Insured & Spouse | Proposed Insured & Child(ren) | Proposed Insured, Spouse & Child(ren) |
| TOTAL MONTHLY PAC PREMIUM: | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| | | | C) TOTAL MONTHLY PAC PREMIUM: \$ _____ | G) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | | |
|---|--|---|--|
| Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (provide name and address in special requests box) | | | |
| Face Amount: \$ _____ Plan: _____ | | | |
| Accidental Death: <input type="checkbox"/> Yes <input type="checkbox"/> No | | D) TOTAL MONTHLY PAC PREMIUM: \$ _____ | |
| Automatic Premium Loan: <input type="checkbox"/> Yes <input type="checkbox"/> No | | H) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ | |

PREMIUM PAYMENT INFORMATION

TOTAL MONTHLY PAC PREMIUM: ADD BOXES A THROUGH D AND ENTER TOTAL HERE:
\$ _____

PAYMENT MODE: (check one) Annual Semi-Annual Quarterly (Not Available for Dental)
 Monthly PAC or Credit Card

IF YOU CHOSE A PAYMENT MODE THAT IS NOT MONTHLY PAC, : ADD BOXES E THROUGH H AND ENTER TOTAL HERE:
\$ _____

PAYMENT METHOD: (check one) Credit Card PAC Direct Bill (Annual, Semi-Annual, Quarterly Only)

Monthly premiums only available by automatic debits to either your checking account or Visa/MasterCard account. Semi-Annual and Annual premiums may be paid by either of these two methods or you may elect to have the company mail you a bill for each premium due.

You must enclose a check for the first Premium payment along with this Application. The amount of the first Premium payment for the Premium Mode you have selected is: \$ _____.

INSTRUCTIONS TO AGENTS — THIS STATEMENT MUST BE COMPLETED WITH APPLICATION

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be payable to Constitution Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the Proposed Insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the applicant does does not own existing inforce policies or contracts on the Proposed Insured. I personally did see did not see the applicant at the time of the application.

| | |
|--------------------|-----------------------|
| Agent Name (Print) | Agent Signature |
| Agent Number | Agent State ID Number |
| Agent Phone | Agent Email |

SERFF Tracking Number: UNAM-127375528 State: Arkansas
 Filing Company: Constitution Life Insurance Company State Tracking Number: 49589
 Company Tracking Number: CL-MP-11-APP-AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Multi Product Application
 Project Name/Number: /

Supporting Document Schedules

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Bypassed - Item: Flesch Certification | Approved-Closed | 08/19/2011 |
| Bypass Reason: N/a | | |
| Comments: | | |

| | Item Status: | Status Date: |
|---|---------------------|---------------------|
| Satisfied - Item: Application | Approved-Closed | 08/19/2011 |
| Comments: | | |
| Attachment: CL-MP-11-APP-AR.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Bypassed - Item: Health - Actuarial Justification | Approved-Closed | 08/19/2011 |
| Bypass Reason: N/A | | |
| Comments: | | |

| | Item Status: | Status Date: |
|---|---------------------|---------------------|
| Bypassed - Item: Outline of Coverage | Approved-Closed | 08/19/2011 |
| Bypass Reason: N/A | | |
| Comments: | | |

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Bypassed - Item: PPACA Uniform Compliance Summary | Approved-Closed | 08/19/2011 |
| Bypass Reason: N/A | | |
| Comments: | | |

CONSTITUTION LIFE INSURANCE COMPANY

Home Office: Houston, Texas Administrative Office: PO Box 13547; Pensacola, FL 32591-3547 · (800) 789-6364

APPLICATION FOR:

- | | |
|---|--|
| <input type="checkbox"/> First Diagnosis of Cancer Insurance <input type="checkbox"/> Hospital Indemnity Insurance | <input type="checkbox"/> Whole Life Insurance <input type="checkbox"/> Supplemental Senior Dental Insurance |
|---|--|

APPLICATION DATE

____/____/____
MM DD YYYY

REQUESTED EFFECTIVE DATE

____/____/____
MM DD YYYY

POLICYHOLDER

New Current Reinstatement
 Policy No.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

| | | |
|----------------------|---------------------------------|--------------------------|
| Mgr./Commission Code | District Sales Manager/Marketer | Application Reviewed By: |
|----------------------|---------------------------------|--------------------------|

Mail Policy To: Insured Agent

APPLICANT INFORMATION

APPLICANT TO BE INSURED

| | | | | | |
|--|----------------|--------------------------------------|-------------------------------|---------------------------------|---------|
| Name (First/Middle/Last) | | | Social Security Number | | |
| Address (Street / Rural Route) | | | | | |
| City | County | State | Zip | | |
| Birthdate (MM/DD/YYYY) | State of Birth | Age | Male <input type="checkbox"/> | Female <input type="checkbox"/> | |
| Home Phone (____) _____ Area Code | | Cell Phone (____) _____ Area Code | | | |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single | | Occupation: _____ | | Height: | Weight: |

SPOUSE TO BE INSURED

| | | | | | |
|---|----------------|-----|-------------------------------|---------------------------------|--|
| Name (First/Middle/Last) | | | Social Security Number | | |
| Birthdate (MM/DD/YYYY) | State of Birth | Age | Male <input type="checkbox"/> | Female <input type="checkbox"/> | |
| Hospital Indemnity Only (Insured Spouse) Beneficiary: _____ | | | Relationship: _____ | | |

CHILD(REN) TO BE INSURED (PRINT FIRST NAME, MI, LAST NAME)

| First | Middle | Last | Gender | Age | Date of Birth | | | State of Birth |
|-------|--------|------|--------|-----|---------------|-----|------|----------------|
| | | | | | Month | Day | Year | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

For additional children, please attach a separate piece of paper, signed by the proposed insured and including all of the above information for each child.

IF OWNER IS NOT PROPOSED INSURED FOR ANY PRODUCT, COMPLETE THE FOLLOWING:

| | |
|---------------------------------|---|
| Owner: | Relationship: |
| Birthdate (MM/DD/YYYY): | Social Security / Tax ID Number: |
| Address (Street / Rural Route): | City: State: Zip: |

IF APPLYING FOR WHOLE LIFE INSURANCE OR HOSPITAL INDEMNITY INSURANCE, PROPOSED INSURED SHOULD PROVIDE THE FOLLOWING BENEFICIARY INFORMATION:

Primary Beneficiary of the Proposed Insured (indicate percentages if split):

| | |
|---------------|-------------------------|
| Relationship: | Birthdate (MM/DD/YYYY): |
|---------------|-------------------------|

Contingent Beneficiary of the Proposed Insured (indicate percentages if split):

| | |
|---------------|-------------------------|
| Relationship: | Birthdate (MM/DD/YYYY): |
|---------------|-------------------------|

IF APPLYING FOR FIRST DIAGNOSIS OF CANCER INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | Proposed Insured | | Spouse | | Child(ren) | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| 1. In the past 5 years has any person to be insured been hospitalized, treated or been advised by a Medical Professional/Doctor, to have diagnostic procedures and/or follow up for: | | | | | | |
| a. Cancer, Malignancy, Leukemia, Melanoma, Lymphoma, Hodgkin's disease?..... (If "yes," please provide details below.) | <input type="checkbox"/> |
| b. Elevated PSA tests, abnormal pap test or mammogram, tumors, growths, bleeding moles or blood in the stool?..... (If "yes," please provide details below.) | <input type="checkbox"/> |

| Name of Person | Details |
|----------------|---------|
| | |
| | |
| | |

| | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. In the past 10 years has any person to be insured been diagnosed as having, or treated by or advised to be treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); Aids Related Complex (ARC); or tested positive for exposure to the Human Immunodeficiency Virus (HIV)?..... (If answered "yes," that person will not be eligible for coverage.) | | | | | | | <input type="checkbox"/> |
| 3. Tobacco Use Information: To be completed by all Applicants Does any person to be insured now use or have they used tobacco products in any form within the last 12 months?..... (If "yes" complete information below.) | | | | | | | <input type="checkbox"/> |

| Name of Person | Type | Frequency |
|----------------|------|-----------|
| | | |
| | | |

| 4. Is this coverage replacing any health insurance in this or any other company?... (If "yes" complete information below.) | | | | | | | <input type="checkbox"/> |
|--|------------|------------------|----------------|----------|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Company Name and Address | Policy No. | Type of Coverage | Effective Date | Benefits | | | | | | | | |
| | | | | | | | | | | | | |

MAXIMUM COVERAGE AVAILABLE IS \$50,000 FOR ALL COVERAGES IN FORCE

| 5. Does any person to be insured have any First Diagnosis of Cancer lump sum coverage currently in force with this Company or any other company?..... (If "yes," complete the following.) | | | | | | | <input type="checkbox"/> |
|---|---------|-----------------------------|--------------------|--|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Name of Person | Company | Policy Description/Form No. | Amount of Coverage | | | | | | | | | |
| | | | \$ | | | | | | | | | |
| | | | \$ | | | | | | | | | |
| | | | \$ | | | | | | | | | |

IF APPLYING FOR LIMITED BENEFIT HOSPITAL INDEMNITY INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | Proposed Insured | | Spouse | | Child(ren) | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| 1. Are you currently bedridden, confined to a wheelchair, in a hospital or nursing home, receiving home health care or been hospitalized 3 or more times in the past 2 years?..... | <input type="checkbox"/> |
| 2. Within the past 5 years have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) or have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?... | <input type="checkbox"/> |
| 3. Within the past 2 years have you had, been advised you may have, been diagnosed or treated by a medical professional for Alzheimer's disease, senile dementia, organic brain disease?..... | <input type="checkbox"/> |
| 4. Within the past 12 months have you had, been advised you may have, been diagnosed or treated by a medical professional for: | | | | | | |
| a. Diabetes requiring insulin, kidney disease, cirrhosis of the liver, Hepatitis C?... | <input type="checkbox"/> |
| b. Cancer (other than skin basal cell), Leukemia, Hodgkin's disease, Lymphoma or Melanoma?..... | <input type="checkbox"/> |
| c. Congestive heart failure, stroke (CVA), heart attack or any other heart or circulatory disorder requiring surgery?..... | <input type="checkbox"/> |
| d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other respiratory disorder?..... | <input type="checkbox"/> |
| 5. Have you been advised during the past year to have surgery for joint disorder or replacements, or for any heart or circulatory condition that has not been performed?..... | <input type="checkbox"/> |

(If answered "yes" to any of questions 1 - 5 above, the applicant is not eligible for coverage.)

| | Proposed Insured | | Spouse | | Child(ren) | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | YES | NO |
| Is this coverage replacing any health insurance in this or any other company?..... | <input type="checkbox"/> |

If "Yes," give details below:

| Name of Person | Company Name and Address | Policy Number | Type of Coverage | Effective Date | Benefits |
|----------------|--------------------------|---------------|------------------|----------------|----------|
| | | | | | |
| | | | | | |
| | | | | | |

Does any person to be insured have any hospital confinement coverage currently in force with this Company or any other company?
 Yes No

If yes, complete the following:

| Name of Person | Company | Policy Description / Form No. | Amount of Coverage |
|----------------|---------|-------------------------------|--------------------|
| | | | \$ |
| | | | \$ |
| | | | \$ |

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

Does the applicant own existing, in-force policies or contracts on the Proposed Insured? Yes No
 If "Yes," complete details the required replaced form.

Do you now or have you within the last year used tobacco products in any form? Yes No
 If "Yes," please explain:

If applicant answers "Yes" to any question in this section, the Proposed Insured is not eligible for coverage.

1. Is the Proposed Insured currently:
 - a. hospitalized, bedridden, confined to a nursing facility, receiving hospice care, confined to a wheel chair due to disease, or received or awaiting an organ transplant?..... Yes No
 - b. diagnosed with or being treated for a terminal illness?..... Yes No
2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for Alzheimer's Disease, Dementia, Memory loss, ALS (Lou Gehrig's Disease)?..... Yes No
3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for, or been advised by a physician they may have:
 - a. Congestive Heart Failure?..... Yes No
 - b. Cancer, Malignancy, Leukemia, Melanoma, Lymphoma, Hodgkin's disease?..... Yes No
5. In the past 12 months, has the Proposed Insured had been diagnosed with, treated for or been advised by a physician to be treated for:
 - a. Heart Attack, Angina (chest pain), Angioplasty, Heart Surgery, Stent Placement, Stroke or Aneurysm?..... Yes No
 - b. Kidney Dialysis, Alcohol or Drug Abuse/Dependency ?..... Yes No
6. In the past 24 months has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
 - a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Pulmonary fibrosis, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder?..... Yes No
 - b) Parkinson's Disease, Muscular Dystrophy, Kidney Disease/Kidney Failure, Cirrhosis, or other Liver Disease, Sickle Cell Anemia?..... Yes No
7. In the past 24 months, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for:
 - a) Heart Attack, Angina (chest pain), Pacemaker/Defibrillator placement, Heart Surgery, Stroke, Aneurysm or other Heart or Circulatory disorder?..... Yes No
 - b) Alcohol or Drug Abuse/Dependency?..... Yes No
 - c) Diabetes requiring insulin or Diabetic Coma?..... Yes No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder?..... Yes No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing?..... Yes No

Special Requests:

Home Office Use Only:

TO BE COMPLETED BY ALL APPLICANTS

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my insurance will be effective on the date it is issued by the company, except as stated in the Conditional Receipt. I personally completed the above questions. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this insurance.**

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Pharmaceutical Database, or other organization, institution or person, that has records or knowledge of me or any other family member applying for insurance to give to Constitution Life Insurance Company, or its reinsurers, any such information including, but not limited to physical and mental conditions, including psychiatric treatment and/or drug and/or alcohol abuse and/or HIV/AIDS related records. This authorization shall be valid for a period of thirty (30) months from the date signed. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Company's Administrative Office. If this authorization was obtained as a condition of obtaining insurance coverage, my right to revoke is also subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

I AGREE THAT: 1. All answers in this application (a) are true and complete to the best of my knowledge; and (b) will be relied on to determine insurability. 2. If the minimum premium is paid on the date the application is signed, the policy(ies) and rider(s) applied for will be in effect from that date, subject to: (a) underwriting requirements; (b) the terms of the attached receipt; (c) the terms of the policy(ies) and rider(s); and (d) Constitution Life's right to rescind the policy(ies). A minimum premium is an amount equal to the full premium for the mode chosen on the application on the policy(ies) applied for. 3. If the minimum premium is not paid as provided, then no insurance will be in effect unless; (a) during the lifetime of the person proposed for insurance, a policy or rider is delivered and accepted and the entire first premium is paid; and (b) at the time of either delivery and acceptance or payment, whichever is later, all answers in this application are still true and complete to the best of my knowledge. 4. The agent is not authorized to waive the terms of the receipt.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge that all persons to be covered under this policy (or these policies) are not covered also by any Title XIX program (Medicaid, MediCal or any similar name. I acknowledge receiving: (1) An Outline of Coverage (Cancer, Hospital Indemnity and Dental); and (2) "A Guide to Health Insurance for People With Medicare" (For applicants eligible for Medicare).

Application Signed in: _____
City State Date

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank.

TO BE COMPLETED BY ALL APPLICANTS

Amount Paid with Application \$ _____

Dated at _____, this _____ day of _____, _____.

| | | |
|---|--|---|
| _____ Signature of Owner (if other than Proposed Insured) | _____ Signature of Proposed Insured | _____ Signature of Spouse (if insured) |
|---|--|---|

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

Do you have any knowledge or reason to believe that replacement of existing health insurance may be involved? Yes No

| | | |
|-----------------------------|--------------------------------------|------------------------|
| _____ Agent Printed Name | _____ Signature of Licensed Agent | _____% Agent Number |
| _____ Agent Printed Name | _____ Signature of Licensed Agent | _____% Agent Number |

IF APPLYING FOR SENIOR DENTAL INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | | |
|----------------------|---|---|---|
| Plan Deductible: \$0 | Annual Benefit Maximum <input type="checkbox"/> Enhanced (\$6000) <input type="checkbox"/> Standard (\$1500) | A) TOTAL MONTHLY PAC PREMIUM: \$ _____ | E) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |
|----------------------|---|---|---|

IF APPLYING FOR FIRST DIAGNOSIS OF CANCER INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | |
|---|---|---|
| BENEFIT | BENEFIT AMOUNT | MONTHLY PAC PREMIUM |
| First Diagnosis of Cancer Policy Benefit Amount – Proposed Insured | \$ _____ | \$ _____ |
| OPTIONAL RIDER BENEFITS | | |
| <input type="checkbox"/> Spouse First Diagnosis of Cancer Rider Benefit Amount | \$ _____ | \$ _____ |
| <input type="checkbox"/> Child’s First Diagnosis of Cancer Rider Benefit Amount | \$ _____ | \$ _____ |
| | B) TOTAL MONTHLY PAC PREMIUM: \$ _____ | F) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |

IF APPLYING FOR HOSPITAL INDEMNITY INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| POLICY BENEFIT | <input type="checkbox"/> Proposed Insured | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child(ren) |
| Daily Hospital Confinement Indemnity Benefit | \$ _____ Daily Benefit | Daily Benefit 100% of Proposed Insured’s Benefit | Daily Benefit (50% of Proposed Insured’s Benefit) |
| OPTIONAL RIDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump Sum Hospital Confinement Indemnity Benefit | \$ _____ Lump Sum Benefit | Lump Sum Benefit 100% of Proposed Insured’s Benefit | Lump Sum Benefit (50% of Proposed Insured’s Benefit) |
| Durable Medical Equipment Benefit | <input type="checkbox"/> 30% of \$1000 charges per year | <input type="checkbox"/> 30% of \$1000 charges per year | <input type="checkbox"/> 30% of \$1000 charges per year |
| Ambulance Benefit per confinement | <input type="checkbox"/> \$200 per trip | <input type="checkbox"/> \$200 per trip | <input type="checkbox"/> \$200 per trip |
| Accidental Death and Dismemberment Benefit <i>Choose Benefit Level – Principal Sum</i> | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,000 |
| Other _____ | | | |

| | | | | |
|-----------------------------------|-------------------------|--------------------------------------|---|---|
| | Proposed Insured | Proposed Insured & Spouse | Proposed Insured & Child(ren) | Proposed Insured, Spouse & Child(ren) |
| TOTAL MONTHLY PAC PREMIUM: | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| | | | C) TOTAL MONTHLY PAC PREMIUM: \$ _____ | G) OTHER MODE (IF NOT PAC) PREMIUM: \$ _____ |

IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE ANSWER ALL OF THE FOLLOWING:

| | |
|---|---|
| Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (provide name and address in special requests box) | |
| Face Amount: \$ _____ | Plan: _____ |
| Accidental Death: <input type="checkbox"/> Yes <input type="checkbox"/> No | D) TOTAL MONTHLY PAC PREMIUM: \$ _____ |
| Automatic Premium Loan: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

PREMIUM PAYMENT INFORMATION

TOTAL MONTHLY PAC PREMIUM: ADD BOXES A THROUGH D AND ENTER TOTAL HERE:
\$ _____

PAYMENT MODE: (check one) Annual Semi-Annual Quarterly (Not Available for Dental)
 Monthly PAC or Credit Card

IF YOU CHOSE A PAYMENT MODE THAT IS NOT MONTHLY PAC, : ADD BOXES E THROUGH H AND ENTER TOTAL HERE:
\$ _____

PAYMENT METHOD: (check one) Credit Card PAC Direct Bill (Annual, Semi-Annual, Quarterly Only)

Monthly premiums only available by automatic debits to either your checking account or Visa/MasterCard account. Semi-Annual and Annual premiums may be paid by either of these two methods or you may elect to have the company mail you a bill for each premium due.

You must enclose a check for the first Premium payment along with this Application. The amount of the first Premium payment for the Premium Mode you have selected is: \$ _____.

INSTRUCTIONS TO AGENTS — THIS STATEMENT MUST BE COMPLETED WITH APPLICATION

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be payable to Constitution Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the Proposed Insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the applicant does does not own existing inforce policies or contracts on the Proposed Insured. I personally did see did not see the applicant at the time of the application.

| | |
|--------------------|-----------------------|
| Agent Name (Print) | Agent Signature |
| Agent Number | Agent State ID Number |
| Agent Phone | Agent Email |