

**APPLICATION FOR INSURANCE TO
PEKIN LIFE INSURANCE COMPANY**

Please Print in Black Ink

PART ONE

Section I	Name (Last First Middle) (Maiden or former name)		Date of Birth			Age	Place of Birth
			M	D	Y		
Proposed Insured	Home Address		City	State	Zip Code	How Long	Phone No.
							()
	Marital Status	Sex	Height	Weight	Social Security No.	Occupation	
					Title	Duties	
	Current Employer					Phone No.	
	Address					()	

Section II	Spouse/Other Insured (First Middle) (Maiden or former name)		Date of Birth			Age	Place of Birth	
			M	D	Y			
Additional Insureds	Sex	Height	Weight	Social Security No.	Occupation			
					Title	Duties		
	Dependent Children		Age	Date of Birth	Sex	Place of Birth	Height	Weight
			M D Y					
			M D Y					
			M D Y					
			M D Y					

Section III	Name of Applicant/Owner (if other than Proposed Insured) (Applicant must sign Page 4)			Relationship	Social Security No. or Taxpayer I.D. No.
	(Last First Middle)				
Applicant	Address		City	State	Zip

Section IV	Primary Beneficiary (full name)		Relationship	Percent	Date of Birth
				%	M D Y
Beneficiary				%	M D Y
	Contingent Beneficiary (full name)		Relationship	Percent	Date of Birth
				%	M D Y
				%	M D Y

If more than one beneficiary is named, then Pekin Life shall interpret this to mean equal shares to the survivor(s) unless otherwise indicated.
If the beneficiary is a minor, name a trustee.

Section V	PLAN OF INSURANCE	Initial Premium	Initial Ins. Amount	FOR UNIVERSAL LIFE		
		\$	\$			
Policy	ADDITIONAL BENEFITS			<input type="checkbox"/> (1) Level Death: or <input type="checkbox"/> (2) Increasing Death Benefit		
	LIFE	<input type="checkbox"/> Waiver			Planned Modal Premium \$ <input style="width:100px;" type="text"/>	
	<input type="checkbox"/> Accidental Death			SMOKER/NON-SMOKER RATES		
	<input type="checkbox"/> Guaranteed Purchase Option			Basic Insured	Smoker <input type="checkbox"/>	Non-Smoker <input type="checkbox"/>
	<input type="checkbox"/> Spouse Term Insurance			Spouse/Other Insured	Smoker <input type="checkbox"/>	Non-Smoker <input type="checkbox"/>
	<input type="checkbox"/> Children's Term Insurance			Automatic Premium Loan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Accelerated Benefit Rider					
	<input type="checkbox"/> Guaranteed Renewability Option					
	<input type="checkbox"/>					

HEALTH/ DISABILITY	HEALTH PLAN	Form #	Zone	Deductible	Two Million Maximum	Supp. Acc.	Premium
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <input style="width:100px;" type="text"/> (A)
	P.P.O.: Hospital Only <input type="checkbox"/> Doctor and Hospital <input type="checkbox"/>		COINSURANCE: <input style="width:50px;" type="text"/> % of the First <input style="width:100px;" type="text"/>				
	Network <input style="width:100px;" type="text"/>		Physician's Copay: \$ <input style="width:100px;" type="text"/>				
	1. Will this policy replace any other accident or health insurance now in force? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	2. Does any insured have any health insurance in force? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Company		Plan Type		Replacing		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		

CONTINUATION OF APPLICATION FOR INSURANCE TO
PEKIN LIFE INSURANCE COMPANY

PART ONE (Continued)

Section V - Policy (Continued)

**HEALTH/
DISABILITY
(Cont'd)**

3. Are all eligible family members included in the application? Yes No

Explain

DISABILITY PLAN	Mo. Benefit	Occ. Class	Benefit Period (Years)	Average Monthly Income
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	(a) Salary <input style="width: 100%;" type="text"/>
Elimination Period (days)	Other Benefits		Premium	(b) Investments <input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>		\$ <input style="width: 100%;" type="text"/> (B)	(c) Other <input style="width: 100%;" type="text"/>

**Section VI
PREMIUM
INFORMATION**

Send Premium Notice to: Residence Business

Owner (If other than Proposed Insured)

Other (Specify address)

Cash with the Application \$ (exact amount)

Premium payable: Ann. Semi-Ann. Quar. Mo. Pre-Authorized Payment Stmt. Bill Uniplan #M

PART TWO

Section VII - Non-Medical

		Yes	No
1. Has any person named in Sections I or II had any diagnosis, or treatment, within the last 10 years, of:			
a) any disorder of the lungs or respiratory system, such as hay fever or other allergies, asthma, tuberculosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) any disorder of the heart or circulatory system, such as high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins or phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) any disorder of the digestive system, such as ulcer, gastritis, intestinal disorders, colitis, gall bladder, hemorrhoids, hernia, or disorder of the pancreas, liver or spleen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) any disorder of the nervous system, such as epilepsy, convulsions, frequent headaches, paralysis, or mental or nervous disorders (including emotional disorders), or psychological or psychiatric treatment of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) any disorder of the genito-urinary system, such as kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) diabetes or sugar in the urine or disorders of the thyroid, breast or other glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) any disorder of the muscular or skeletal system, such as arthritis, gout, rheumatism, any back pain or disorder of the spine or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) cancer, tumor, cyst or unusual growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) any disorder of the eyes, ears, nose or throat, such as impaired sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) any disorder of the reproductive organs, irregular menstruation, pregnancy complications, such as Caesarean section delivery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or any Proposed Insured been diagnosed as having or been treated for acquired Immune Deficiency syndrome (AIDS) by a member of the medical profession?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any person named in Section I or II, within the past 10 years, been hospital confined, had surgery, or had surgery recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is any person named in Section I or II currently pregnant? If "Yes", indicate anticipated delivery date on page 3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any person named in Section I or II:			
a) smoked cigarettes within the past year? If so list the number of packages per day. <input style="width: 40px;" type="text"/> If the person has quit, list the date <input style="width: 100px;" type="text"/> . If yes, give person's name here: <input style="width: 250px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) used tobacco in any form within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any person proposed for insurance:			
a) applied for or received a disability pension from any source?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) had any application for life, health and accident insurance rejected, rated up, restricted, postponed or withdrawn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) used marijuana, barbiturates, amphetamines, hallucinogens or narcotics or been treated by a doctor or in a hospital or other medical facility because of alcohol, drug or narcotic usage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) had or been advised to have any surgical operations, x-ray, heart study, electrocardiogram or other laboratory examinations within the past 5 years? (Wisconsin residents: Disclosure of blood tests to detect the HIV antibody is limited to the ELISA-ELISA-Western blot series. Information regarding any test performed at an alternate test site designated as such by the state epidemiologist need not be provided.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) used insulin or been on a restricted diet for any purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has there been any change in weight of any Proposed Insured during the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is any Proposed Insured currently taking medication or being given treatment by a physician or medical professional not indicated above in questions 1 through 8?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AGENT'S REPORT

1. Have medical examination arrangements been made? Yes No

Date of examination: Name of examiner:

2. If telephone interview is required, most convenient time to call?

3. what is the purpose of this insurance?

4. Applicant's estimated annual income? \$

5. If the Proposed Insured is under age 15:

a) Are all brothers and sisters insured? Yes No

If "No" give reasons:

b) Did you personally see child? Yes No

c) Life insurance on Payor's life (amount): \$

6. How long have you known the Proposed Insured?

How well?

7. Did you personally interview the Proposed Insured and complete the application in his, or her, presence? Yes No

8. If required, did you collect the oral fluids specimen? Yes No

9. To your knowledge, has any Proposed Insured smoked cigarettes within the past year? Yes No

10. Will the policy applied for replace any existing insurance or annuity? Yes No (If "Yes", follow state regulations.)

11. If a sales ledger was used in your presentation, have you attached a copy of it to the application? Yes No

12. Have you given the Notice of Insurance Practices (including Medical Information Bureau Notice and Fair Credit Reporting Act Notice) to the Proposed Insured? Yes No

I hereby certify that I know nothing affecting the insurability of any Proposed Insured which is not fully set forth in these papers.

Signed at

City and State

Date

Signature of Licensed Agent

Agent Number

**INSTRUCTIONS FOR
PRE-AUTHORIZED PAYMENT PLAN**

There are two sections to be completed by you and returned to us. Please complete both parts as follows:

1. Fill in the name of your Bank, branch (if any), and the city and state in which the bank or branch is located.
2. Please attach a sample of your check - this will help us in determining the bank code numbers. (Write "VOID" across the face of the check.)
3. List all the Pekin policy numbers which you wish to have included in this Pre-Authorized Payment Plan.
4. Please PRINT the name of your account exactly as it appears on your bank statement.
5. Show your Depositor Account Number, if you have been assigned such a number by your Bank (the Depositor Account Number) will usually be found below the signature line on your personal checks).
6. Please SIGN your name exactly as you do on your personal checks.
7. Show the date on which you sign the Authorization Cards.

PEKIN LIFE INSURANCE COMPANY
2505 Court Street Pekin, Illinois 61558

REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN AND/OR LOAN REPAYMENT PLAN

- New Pre-Authorized Payment Plan Addition to Existing Plan Change of Bank
- Pekin Life Insurance Company is hereby requested and authorized to initiate a monthly withdrawal against my (our) checking account for the purpose of collecting premiums on the policies listed below, subject to the following conditions:
- (1) The Pre-Authorized Payment Plan requested herein shall not be effective until approved by the Company.
 - (2) No premium notices shall be given.
 - (3) The Plan may be terminated by the policyowner, or by the depositor if other than the policyowner, or by the Company at any time upon written notice.
 - (4) If the Pre-Authorized Payment Plan is terminated for any reason, any premium then due, and all subsequent premiums, shall be payable as provided in the policy.
- Draw an additional amount of \$ _____ (minimum \$150) beginning in the month of _____ to reduce the loan on Policy Number _____. If at any time this additional payment exceeds the amount necessary to complete the loan repayment, the excess will be refunded, and this portion of the agreement will terminate.

Date: _____

Signature of Policyowner other than Depositor
(only if loan repayment is being requested)

SIGNATURE OF DEPOSITOR(S)

POLICY NUMBERS

COMPLETE REVERSE

**PEKIN LIFE INSURANCE COMPANY • PEKIN, ILLINOIS
CONDITIONAL RECEIPT**

1. NO COVERAGE WILL BECOME EFFECTIVE PURSUANT TO THIS CONDITIONAL RECEIPT UNLESS AND UNTIL ALL OF THE FOLLOWING CONDITIONS HAVE BEEN SATISFIED COMPLETELY AND EXACTLY
 - (a) The amount of payment received with this application must be equal to the full initial modal premium for the amount and plan of life insurance applied for and effective at the time of delivery of the policy.
 - (b) All medical examinations, tests and related data required by the Company must be completed and received at its home office within sixty (60) days from the completion of this application.
 - (c) As of the effective date below, each person proposed for insurance in this application must be on the effective date, 70 years old or younger, insurable in accordance with Company rules, limits, and standards for the plan and the amount applied for without any modifications either as to plan, amount, riders and/or the rate of premium paid.
 - (d) As of the effective date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in this application.
2. If the conditions of paragraph 1 are satisfied on the effective date, insurance coverage will be provided pursuant to this Conditional receipt on the same terms and conditions as the policy applied for and in use on the effective date. However, the amount of such insurance will be in an amount not to exceed that specified in paragraph 3. "Effective date" as used herein, is the latest of:
 - (a) The date of the application, Part 1; or
 - (b) The date of the completion by Insureds of all medical examinations or tests required by the Company; or
 - (c) The date, if any, specifically requested in the application.
3. The maximum total amount of insurance, which will be payable pursuant to all Conditional Receipts received by the Applicant as a result of pending applications with the Company is limited to the smaller of:
 - (a) The total amount of insurance applied for with the Company; or
 - (b) \$250,000 minus the total amount of insurance in force with the Company, but not less than zero.

As used above, total amount of insurance includes any amounts payable under any Accidental Death Benefit provision.

If one or more of the conditions in paragraph 1 on any insured have not been satisfied completely and exactly or the proposed insured dies by suicide, there shall be no liability on the part of the Company pursuant to this Conditional Receipt, except to return the applicable premium paid for coverage on that insured.
4. Any insurance in effect pursuant to this Conditional Receipt will end at the earliest of:
 - (a) The date notice is mailed that the application is not accepted; or
 - (b) At the end of sixty (60) days from the date of this Conditional Receipt; or
 - (c) The date on which coverage under this policy applied for becomes effective.

NO AGENT OR ANY OTHER PERSONS IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY ANY OF THE PROVISIONS OF THIS CONDITIONAL RECEIPT.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received the sum of \$ _____ from _____ in connection with the application for life insurance bearing the same date as this Conditional Receipt

Dated at _____ this _____ date of _____, 20 _____.

X

Signature of Agent/Registered Representative

I acknowledge possession of this receipt. I certify that I have read it and the terms in the Application. I also certify that the Agent/Insurance Producer has explained the provisions in paragraph No. 3, other terms of this Conditional Receipt and the terms in the Application to me and that I understand and accept them.

X

Signature of Applicant

DO NOT DETACH UNLESS FULL FIRST PREMIUM IS PAID WITH APPLICATION

Pekin Life Insurance Company

Public Law 91-508, known as the Fair Credit Reporting Act, requires that we advise you that a routine inquiry may be completed which provides applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report will be provided.

Information regarding your insurability will be treated as confidential. Pekin Life Insurance or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau file, you may contact the bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston Massachusetts 02112, telephone number (617) 526-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. You may request to be interviewed - if you are not, you may request a copy.

AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED PAYMENTS WITH
PEKIN LIFE INSURANCE COMPANY

To: _____
(Financial Institution Name)

Address: _____

I hereby authorize and request Pekin Life Insurance Company to effect payment for monthly premiums payable by me to Pekin Life Insurance Company by initiating debit entries including checks, drafts, and other orders whether by electronic or paper means, to my account indicated below at the financial institution named above. I authorize and request you as a convenience to me to honor and accept debit entries initiated by Pekin Life Insurance Company to my account and to debit the same to such account. I further agree that if any such debit is not paid by you for any reason, with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such nonpayment results in the forfeiture of insurance.

This authority is to remain in full force and effect until Pekin Life Insurance Company has received written notice from me of its termination in such time and in such manner as to afford Pekin Life Insurance company a reasonable opportunity to act.

Savings Checking

Customer Name(s)	Date	Account No.
X _____	_____	_____
Signature(s)*		Transit Routing No.

*Your signature(s) as shown on financial institution records and as used in the account

INDEMNIFICATION AGREEMENT

To: The Bank Named on the Authorization

In consideration of your compliance with your depositor's request and authorization appearing on the reverse side,

PEKIN LIFE INSURANCE COMPANY AGREES THAT:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any withdrawal by Pekin Life Insurance Company to its own order on the account of such person (or from any liability to any such person or to any owner or beneficiary of any policy issued by Pekin Life Insurance Company in respect of which such withdrawal) arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such withdrawal by Pekin Life Insurance Company whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance, the premium on which is sought to be collected by Pekin Life Insurance company by any such withdrawal; and
2. It will refund to you any amount erroneously paid by you to Pekin Life Insurance Company on any such withdrawal if claim for the amount of such erroneous payment is made by you within twelve months from the date of the withdrawal on which such erroneous payment was made.

PEKIN LIFE INSURANCE COMPANY

NOTICE OF INSURANCE PRACTICES

The application you completed is our most important source of information. Pekin Life Insurance Company may request information from Physicians whom you or one of your family members may have consulted. We may also request information from Insurance Support and Institutional Source organizations. This information may include statements regarding past medical history, current medical conditions and/or prognosis from your Physician. It may also include information concerning character, general reputation, personal characteristics and mode of living. You may request to be interviewed or you may request a copy.

This information may be received through correspondence with your Physician, who may make a report to Pekin Life Insurance Company. Physicians or medically qualified personnel to whom you may be referred for medical examination or other specific medical information, or business that engage in Consumer Investigation reports, or other Insurance Companies that you may have applied with during previous insurance negotiations. Information received during our investigation will be treated as confidential and released to no person or organization without your authorization. Except that Pekin Life Insurance Company may make a brief report to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates as information exchange on behalf of its members. We may also provide personal and medical information to Reinsurance Companies for the purpose of purchasing reinsurance over the limits our Company retains.

You have the right to review personal information received during the investigation. You may correct or amend information we receive. Reports completed by Insurance Support organizations may be retained by that organization and disclosed to other persons.

If you wish to review information we receive for accuracy, send a written request to Pekin Life Insurance Company. A description of procedures which may allow you access to the information will be provided.