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**Simplified Application  
For  
Life Insurance**

**Ages 0-60    Face Amounts \$5,000 - \$75,000**

**Grange Life Insurance Company**

650 South Front Street : P.O. Box 1218  
Columbus, OH 43216-1218  
614-445-2900

**NOTICE OF INFORMATION PRACTICES  
(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)**

**This Notice Must Be Given To Proposed Insured**

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you.

Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the MIB, Inc. (Medical Information Bureau), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the the information 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's 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life companies to whom you apply for life or health insurance, or to whom a claim is submitted. MIB information will only be released to MIB, Inc. members.

In addition, we may get an Investigative Consumer Report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

**Grange Life Insurance Company  
Columbus, Ohio 43206**

**(Do not detach unless the full First Premium is paid with Application.)**

**CONDITIONAL COVERAGE RECEIPT**

No. \_\_\_\_\_

COVERAGE PROVIDED BY THIS RECEIPT SUBJECT TO ALL EXCLUSIONS AND PROVISIONS OF THE POLICY APPLIED FOR. THIS RECEIPT PROVIDES A LIMITED AMOUNT OF INSURANCE, FOR A LIMITED PERIOD OF TIME, AND THEN ONLY IF ALL THE TERMS AND CONDITIONS ARE MET. NO AGENT CAN ALTER OR WAIVE ANY OF THE PROVISIONS OF THIS RECEIPT. IT IS VOID IF ALTERED OR TRANSFERRED.

RECEIVED:  Cash or Check in the amount of \$ \_\_\_\_\_ from \_\_\_\_\_  
as conditional payment on the lives of the Proposed Insured(s). \_\_\_\_\_

An application for insurance bearing the same number and date as this Receipt is this day made to Grange Life Insurance Company. This conditional payment is subject to the conditions set out below. This Receipt is void and there is no insurance if such payment is by check or draft and it is not honored by the bank when presented for payment. If the insurance applied for does not become effective, any money or authorization received will be returned to the Owner. All premium checks must be payable to GRANGE LIFE INSURANCE COMPANY.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY - Unless each and every condition below has been fulfilled exactly, the insurance will become effective only as described in the Declarations section of the application.

EFFECTIVE DATE OF COVERAGE - Insurance issued based on the application will take effect, subject to the Conditions below, on the latest of: (1) the date of the application; or (2) the date requested in the application; or (3) the date of the last of any medical examinations or tests required under Grange's rules and practices.

CONDITIONAL COVERAGE - Insurance issued based on the application will take effect only if these conditions are met: (1) on the Effective Date the Proposed Insured(s) is (are) qualified exactly as applied for under Grange's rules and practices for the plan, amount and premium rate applied for; and (2) the amount paid with the application is equal to the full first premium for the insurance; and (3) the maximum Amount of Coverage specified below is not exceeded.

AMOUNT OF COVERAGE - \$250,000 MAXIMUM INSURANCE - In no event will the amount of life insurance which may become effective under this Receipt when added to the amount of insurance in force or applied for with Grange, exceed \$250,000. If the application is for insurance in excess of this amount, any excess insurance will become effective only as described in the Declarations section of this application.

TERMINATION AND REFUND OF PREMIUM - If the application to which this Receipt was attached is not approved as applied for by Grange within ninety days from its date, this Receipt shall be void. Grange's only liability in such event will be to return any money received.

**THIS RECEIPT IS NOT VALID UNLESS SIGNED BY A LICENSED AGENT OF GRANGE.**

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Premium Submitted: \$ <input style="width:150px;" type="text"/>	<b>Grange Life Insurance Company</b> 650 South Front Street, PO Box 1218 Columbus, Ohio 43216-1218 <b>SIMPLIFIED APPLICATION</b>	Base Plan _____ Face Amount \$ <input style="width:150px;" type="text"/> Include Riders <input type="checkbox"/> WP <input type="checkbox"/> LTC <input type="checkbox"/> _____ Face Amount \$ <input style="width:150px;" type="text"/> Include Riders <input type="checkbox"/> WP <input type="checkbox"/> LTC <input type="checkbox"/> _____ Face Amount \$ <input style="width:150px;" type="text"/>
Payment Mode: <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> Q <input type="checkbox"/> PAC <input type="checkbox"/> List		
Universal Life: Death Benefit Option: <input type="checkbox"/> A <input type="checkbox"/> B		
Whole Life: Nonforfeiture Option will be Extended Term Insurance for Regular Premium Class or Paid Up Insurance for Special Premium Class unless stated: _____		
Automatic Premium Loan: <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Proposed Insured # 1</b>	1. Proposed Insured	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	
	2. Date of Birth	<input style="width:50px;" type="text"/> / <input style="width:50px;" type="text"/> / <input style="width:50px;" type="text"/>	Place of Birth <input style="width:100px;" type="text"/>	Height <input style="width:50px;" type="text"/>	Weight <input style="width:50px;" type="text"/>	<input style="width:100px;" type="text"/> (Taxpayer-I.D. Number)
	3. Home Address	<input style="width:100%;" type="text"/>				
	4. <input type="checkbox"/> Working <input type="checkbox"/> In School	<input style="width:100%;" type="text"/> (Occupation / Name of School)				<input style="width:100px;" type="text"/> (Municipality)
	5. Beneficiary Information	<input style="width:100px;" type="text"/> (Name)	<input style="width:100px;" type="text"/> (Relationship)	<input style="width:100px;" type="text"/> (Share)		
		<input style="width:100px;" type="text"/> (Name)	<input style="width:100px;" type="text"/> (Relationship)	<input style="width:100px;" type="text"/> (Share)		

<b>Proposed Insured # 2</b>	1. Proposed Insured	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	
	2. Date of Birth	<input style="width:50px;" type="text"/> / <input style="width:50px;" type="text"/> / <input style="width:50px;" type="text"/>	Place of Birth <input style="width:100px;" type="text"/>	Height <input style="width:50px;" type="text"/>	Weight <input style="width:50px;" type="text"/>	<input style="width:100px;" type="text"/> (Taxpayer-I.D. Number)
	3. Home Address	<input style="width:100%;" type="text"/>				
	4. <input type="checkbox"/> Working <input type="checkbox"/> In School	<input style="width:100%;" type="text"/> (Occupation / Name of School)				<input style="width:100px;" type="text"/> (Municipality)
	5. Beneficiary Information	<input style="width:100px;" type="text"/> (Name)	<input style="width:100px;" type="text"/> (Relationship)	<input style="width:100px;" type="text"/> (Share)		
		<input style="width:100px;" type="text"/> (Name)	<input style="width:100px;" type="text"/> (Relationship)	<input style="width:100px;" type="text"/> (Share)		

<b>Dependent Children</b>	Name (Last	First	Middle)	Sex	Date of Birth	Age	State of Birth	Height	Weight
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.
								ft. in.	lbs.

<b>For Wisconsin Applicants Only: Test results of AIDS/HIV received at anonymous counseling and testing sites or results from a home test kit need not be disclosed.</b> <i>Please explain "yes" answers in space provided below, to include name, address, and phone numbers.</i>	<b>Proposed Insured # 1</b>	<b>Proposed Insured # 2 / Dependent Children</b>
6. a. Will this insurance replace any other insurance? (If "yes", forward replacement form.) .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Has an application for life or health insurance on any proposed insured been postponed or offered with any extra premium charge? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. a. To the best of your knowledge has any proposed insured been told by a doctor that he or she had a heart attack, stroke, cancer or high blood pressure? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. a. In the past 10 years has any proposed insured been treated by a member of the medical profession for any other physical impairment or disease? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Has any proposed insured engaged in scuba, aviation, sky diving, organized racing, hang gliding or ballooning in the last 5 years? (If "Yes", give details.) .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Has any proposed insured ever been medically diagnosed or treated by a member of the medical profession for AIDS, OR AIDS related complex (ARC), or tested positive for the HIV virus or had any disease or disorder of the immune system? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. In the past 10 years has any proposed insured been treated for drug or alcohol abuse? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. In the past 3 years has any proposed insured been arrested for DWI, a felony, a misdemeanor, or had a driver's license restricted or revoked? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Is there any test, hospitalization or surgery scheduled for any proposed insured in the next 60 days? .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Has any proposed insured used tobacco products within the past 24 months? (If "yes", provide details.) .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Proposed Insured Name	Details	Physician Name, Address & Phone Number

<b>Applicant/ Owner/ Payor</b>	Name of Applicant / Owner (if other than Proposed Insured # 1)	Relationship	Taxpayer I.D. Number	
	Address (Number & Street)	City	State	Zip
All notices and reports will be sent to the Owner unless otherwise specified here: _____				

To the best of my knowledge and belief, the statements above are true and complete. The above statements will be the basis for any insurance issued. The entire contract will consist of the policy and this application. **No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full premium is paid. However, if the full final premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.**

Agreements: All physicians, medical practitioners, hospitals, clinics, or other medically-related facilities, insurance companies, or MIB Inc., are authorized to release to Grange Life Insurance Company or its reinsurers any records regarding my health. This includes information about drugs and alcohol and about diagnosis, treatment, and prognosis of any physical or mental condition. This authorization shall be valid for 30 months from the date shown below. I may obtain a copy of this if I ask for it. A photo copy shall be valid as the original.  
I acknowledge receipt of the Notice of Information Practices.

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**Pre-Authorized Check Authorization:**  
: If P.A.C. (Pre-Authorized Check) withdrawals are requested, please complete the following information:  
⊖ An amount equaling at least two months withdrawals must be submitted with this application to begin a P.A.C. account.

I hereby authorize my bank to make payments to my policy on a monthly basis from my checking account:  
 Yes  No Bank Name: \_\_\_\_\_ Checking Account Number: \_\_\_\_\_

**Please Note - The initial bank draft may be in the amount of two monthly withdrawals to meet the minimum contribution requirements when insufficient monies accompany this application. Subsequent withdrawals will occur on the same day of each month as your contract date.**

**>>>>> PLEASE ATTACH VOIDED CHECK (Please do not attach Deposit Slips) <<<<<<**

P.A.C. drafts can be discontinued by the policyowner at anytime upon written request to the **Grange Life Home Office.**

*Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information may be subjected to criminal penalties and the denial of coverage for claims made under the policy of insurance.*

**WE ARE REQUIRED BY LAW TO GIVE YOU THE FOLLOWING NOTICE:**  
*Ohio and Tennessee* - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.  
*Kentucky* - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.  
*Pennsylvania* - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**HOME OFFICE ENDORSEMENTS**

Not to be used where prohibited by Statute or Insurance Department ruling.  
Not applicable in any state where Written Consent is required by law.

Dated _____	(X) _____	Signature of Proposed Insured # 1
Signed At _____ City and State	(X) _____	Signature of Proposed Insured # 2
Witnessed By Agent _____	(X) _____	Signature of Applicant/Owner if Other than Proposed Insured # 1 or # 2 (If a corporation, state corporation name)
Agent Name & Agent Number (please print) _____	(X) _____	Signature of Corporate Officer

Agency Number:  -

(Agent's Report) Will this policy replace insurance with any other company?  Yes  No

Proposed Insured Annual Income \$

Agent Signature \_\_\_\_\_ Agent Number:  -  -  -