Worksite Marketing Transmittal

Applicant/Company Information:

Employee / Insured Name: ______________________ Requested Policy Date: ______ / 01 / ______ (Month / Year)

Employer Name: ______________________

We may need to contact the applicant for more information during the underwriting process. Total Deduction Amount: ______________

Please advise the best time and place to contact the applicant: ______________________

Items Enclosed:

Enclosed	Document
☐	Application (including HIPAA Authorization)
☐	Replacement Form *
☐	Illustration or Certificate (below) **
☐	Other ______________

* If replacement is involved, the replacement form must be received with the application, and signed the same date as the application.

** The complete illustration or certificate below needs to be signed the same date as the application and submitted with the application.

Instructions:

Please make certain . . .

1. The Notice of Information Practices is delivered to the proposed insured before completion of the application.
2. The Payroll Deduction Authorization is completed and given to the Employer.
3. The proposed insured, spouse and applicant/owner (if any) sign the application form where indicated.
4. All sections of the application required for coverage are complete.
5. The personal physician and medical information is disclosed, as this will help expedite the underwriting process. Incomplete medical history will delay the underwriting process.
6. The agent name and agent number is clearly written.
7. If additional room is needed for medical history, children's information, etc., a separate form can be attached.
8. If this coverage is for $101,000 or more, the full application (L-3-22) should be used.

Illustration Certificate:

Applicant: I acknowledge that no illustration conforming to the policy applied for was provided and understand that an illustration conforming to the issued policy will be provided no later than at the time of policy delivery.

Applicant Signature ______________________ Date ______________

I certify that no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for.

Agent Signature ______________________ Date ______________

L-3-45 (12-2009)

NOTICE OF INFORMATION PRACTICES **This Notice Must Be Given To Proposed Insured**

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

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 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 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number 866-692-6901.

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 it 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, a well as any additional rights which you may have.

Grange Life Insurance[SM]

Sensible Benefits Life Application

N B

1. Coverage Applied For:

Base Plan: **Face Amount**
☐ Term 10 Year $ ____________
☐ Term 20 Year $ ____________
☐ Universal Life $ ____________
☐ Whole Life $ ____________
☐ Graded Death Benefit $ ____________

Includes Riders: ☐ Child ($10,000) ☐ Waiver
☐ Accidental Death Benefit ____________________

Universal Life: Death Benefit Option Level - A (Level) B (Increasing)
Whole Life: Non-forfeiture Option will be extended term for regular premium class or paid-up insurance for special premium class unless stated: ____________ Automatic Premium Loan: ☐ Yes ☐ No

Payment Mode: ☐ 13thly (Use for persons paid weekly or bi-weekly)
☐ Monthly (Use for persons paid semi-monthly or monthly)

Group Name: ____________________
Group Number: (if existing group) ____________

2. Proposed Insured:

Employee Name: ____
First Middle Last

Social Security No: ____________
Phone Number: (___) ____________

Proposed Insured: ____
First Middle Last

Social Security No.: ____________
Phone Number: (___) ____________

☐ Male ☐ Female Date of Birth: ____________ State of Birth: ____________ Height: ______ Weight: ______
Month Day Year

Marital Status: ____________

Home Address: ____________________ City: ____________ State: ________ Zip: ________

Drivers License Number: ____________________ Occupation: ____________________

3. Policyowner:

Policyowner (if other than insured): ____________________ Tax ID # / Social Security No.: ____________

Home Address: ____________________ City: ____________ State: ________ Zip: ________

4. Beneficiary:

Beneficiary: Primary: ____________________ _____ % Relationship: ____________

Contingent: ____________________ _____ % Relationship: ____________

5. Dependent Children (if proposed for coverage)

Name - Last	First	Middle	Sex	Date of Birth	Age	State of Birth	Height	Weight

6. Replacement:

Will the coverage applied for replace or change any existing or applied for life insurance or annuity? ☐ Yes ☐ No
If Yes, provide company name, amount of coverage, issue date, and type of coverage below, and complete applicable Replacement Form(s).

Insured	Company	Amount	Issue Date	Type of Coverage

7. Tobacco Use:

Has any proposed insured used tobacco in any form in the last 24 months? ☐ Yes ☐ No
If Yes, form used? ☐ Cigarettes Other ____________ No. per day? ______ For how long? _____ years.

8. Employee only:

For Wisconsin Applicants Only: The AIDS/HIV testing is limited to the results of FDA-licensed blood tests and the applicant need not report the results of the tests conducted at an anonymous counseling and testing site, or home test results.

1. Has the proposed insured missed more than 5 days of work due to sickness or injury in the past 6 months or is he/she not currently actively at work? ☐ Yes ☐ No
2. Has the proposed insured ever been diagnosed as having or been treated for AIDS (**Acquired Immune Deficiency Syndrome**) or ARC (**Aids Related Complex**) by a member of the medical profession, or tested positive for HIV Antibodies as part of a test conducted for the purpose of obtaining insurance? ☐ Yes ☐ No

If both questions are answered "No", the proposed insured qualifies for the Graded Death Benefit Whole Life plan.

All proposed insureds must answer the following:

9. Personal Physician:

Name of your primary physician or health care provider and date/reason last consulted.

Insured Name	Personal Physician	Address, City, State, Zip Code	Phone #	Date Last Consulted - Reason

10. Medical Questions:

For Wisconsin Applicants Only: The AIDS/HIV testing is limited to the results of FDA-licensed blood tests and the applicant need not report the results of the tests conducted at an anonymous counseling and testing site, or home test results.

Please explain "yes" answers in the space provided below - include name, address, and phone numbers.

Question	Proposed Insured	Dependent Child
1. Has an application for life or health insurance on any proposed insurance been postponed or offered with any extra premium charge?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 10 years, has any proposed insured been told by a doctor that he / she had a heart attack, stroke, cancer or high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
3 a. In the past 10 years has any proposed insured consulted a member of the medical profession for any other physical impairment or disease?	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any proposed insured engaged in scuba, aviation, sky diving, organized racing, hang gliding, or ballooning in the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ Yes ☐ No
d. In the past 10 years has any proposed insured been treated for drug or alcohol abuse?	☐ Yes ☐ No	☐ Yes ☐ No
e. In the past three years has any proposed insured been arrested for DUI, a felony, misdemeanor, or had a Driver's license restricted or revoked?	☐ Yes ☐ No	☐ Yes ☐ No
f. In the next 60 days are there plans for any proposed insured to be hospitalized for surgery or tests?	☐ Yes ☐ No	☐ Yes ☐ No

Proposed Insured's Name	Details	Physician Name, Address, Phone Number

11. Remarks or Special Instructions:

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.

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.

IN ALL OTHER STATES, THE FOLLOWING APPLIES:

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.

12. Signatures:

Dated ______________________ ______________________
Signature of Proposed Insured

Signed At ______________________ ______________________
Signature of Applicant/Owner if other than Proposed Insured

Agent's Report: 1. Will this policy replace any other insurance with another company? ☐ Yes ☐ No
2. Kentucky Only - Does the insured reside in a municipality? ☐ Yes ☐ No If yes, (Municipality)______________

______________________ ______________________
Witnessed By Agent (Please Print) Agency Name

Agent Number: ______________

____
Agents Signature

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, Ohio 43216-1218

HIPAA Compliant Authorization for Release of Medical Information

____ ____/____/____
Name of Proposed Insured/Patient (**please type or print**) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, including any facility run by the Veteran's Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, or the medical records of my minor children, prescription history, medications prescribed and any other protected health information concerning me or my minor children to Grange Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. This information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Grange Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Grange Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original.* I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Grange Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Grange Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Grange Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

I authorize Grange Life Insurance to obtain an investigative consumer report on me. In connection with any investigative consumer report,

I/We ☐ do ☐ do not request a personal interview.

I have received a copy of the Notice of Information Practices.

* **Virginia Only:** The authorization to disclose protected health information in connection with a claim for benefits under this policy will remain valid during the claims review process.

Date: __________________________

____
Signature of Proposed Insured #1
Personal Representative

____
Signature of Proposed Insured #2
Personal Representative

____
Signature of Parent or Guardian,
if minor child(ren) proposed for insurance

(x) ____________________________________
Description of Personal Representative's Authority
or Relationship to Patient

Sensible Benefits
Payroll Deduction Authorization
(Please submit this form to Employer)

Employee: ______________________ Social Security Number: ______________________

Employer: ______________________

1. Amount of Deduction

Employee	______________________	$ ____________
Child Rider	______________________	$ ____________
Spouse	______________________	$ ____________
Child Rider	______________________	$ ____________
Children	______________________	$ ____________
	______________________	$ ____________
	______________________	$ ____________
	______________________	$ ____________
	Total Deduction Amount	$ ____________

2. Deduction and Date Information

Frequency of Deduction	Total Deduction Amount	Date of Initial Deduction	Proposed Effective Date
☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly	$ ____________	____________	____________

3. Deduction Authorization

I hereby, authorize my Employer, named above, to deduct from my salary (or wages) the payment stated above as consideration for contracts issued by Grange Life Insurance Co., Columbus, Ohio, as they fall due during the continuance of my employment by said Employer or until this authorization is revoked by me, by written notice to the said employer.

______________________ ______________________

Date Signed Employee Signature

4. Waiver of Participation

My signature below certifies that I have been made aware of the features and benefits of the plan offered to me as an optional benefit through my employer, and I have decided not to participate at this time.

______________________ ______________________

Date Signed Employee Signature