



**Simplified Application
For
Life Insurance**

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

Grange Life Insurance Company

671 South High Street • P.O. Box 1218
Columbus, OH 43216-1218
800-399-3797

**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 _____

L-3-33 (02-2009)

Applicant/ Owner/ Payor	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:			Municipality:

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.**

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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.**

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 NOTICE 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.

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 _____ (X) _____
 City and State **Signature of Proposed Insured # 2**

_____ (X) _____
Witnessed By Agent **Signature of Applicant/Owner**
if Other than Proposed Insured # 1 or # 2
(If a corporation, state corporation name)

_____ (X) _____
Agent Name & Agent Number (please print) **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: _____



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 is valid for the duration of a claim if it is for the purpose of administering a claim for benefits under the insurance policy.

Date: _____

(x) _____
Signature of Proposed Insured #1
Personal Representative

(x) _____
Signature of Proposed Insured #2
Personal Representative

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

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