❐ The Ohio National Life Insurance Company
❐ Ohio National Life Assurance Corporation
Please print all answers in ink.

One Financial Way
Cincinnati, Ohio 45242
P.O. Box 237
Cincinnati, Ohio 45201-0237

# Preliminary Life Insurance Application

**Policy Number** ________________________

## Proposed Insured Information

**1.** Name  Sex: ❐ M ❐ F

**2.** Social Security Number

**3.** Date of Birth

**4.** Address  City  State  Zip Code

**5.** State or Country of Birth

**6.** Telephone Number
Day: ( )  Evening: ( )  Best Time To Call:

## Owner and Beneficiary Information/Policy Information

**7.** Owner's Name, other than Insured ________________________
*(If two or more persons are designated, their interests shall be joint and survivor.)*  Relationship to Insured

**8.** Primary Beneficiary(ies) ________________________
*("Children" shall mean children born to or legally adopted by the Insured.)*  Relationship to Insured

**9.** Plan of Insurance ________________________ Amount $ ____________

**10.** Riders and Benefits ________________________

**11.** Premium Mode ❐ A ❐ S ❐ Q ❐ ABC ❐ SS/List Bill

**12.** Will proposed policy replace or cause change in any existing policy? ❐ Yes ❐ No

**13.** Have you been diagnosed as having or been treated for heart attack, stroke or cancer within the last two years; or been advised to have surgery which has not been performed? ❐ Yes ❐ No If you answered "Yes" to question 14, or are applying for more than $1 million of coverage, temporary insurance is not available. Answer question 15 "No."

**14.** Is money submitted with this application? ❐ Yes ❐ No  Amount remitted $____________

## Mutual Agreements and Authorization to Obtain and Disclose Information

This Preliminary Life Insurance Application initiates the process for completion of the full application. No coverage will be in effect, except for any limited temporary insurance agreement, until a full application has been completed and signed by the Applicant, a policy has been delivered to the applicant, and the full first premium has been paid during the lifetime of the Insured. Any coverage will be subject to the terms and conditions of the policy and rider(s).

**AUTHORIZATION** to any physician; practitioner; hospital, clinic or other medical or medically related facility; health care provider; insurance company or reinsurance company; insurance support organization; the Veterans Administration; the Medical Information Bureau, Inc. (MIB); a consumer reporting agency; and/or employer:

In order to enable Ohio National Life to act upon my application for insurance or to decide if I qualify for benefits or coverage, I authorize you to give to Ohio National Life any and all information, records or knowledge which you have about my physical or mental condition. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, and includes information about drugs, alcoholism or mental illness. You may also give Ohio National Life any financial, employment or personal information requested for insurance purposes.

Ohio National Life may release information to reinsurance companies, to MIB, or to others who perform business or legal services related to my application or the policy or claim thereunder. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

- This authorization is good, as needed, for 26 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I have received the Notice of Information Practices.
- I understand that I have the right to receive a copy of this authorization.

If signing for someone, also check here and identify below.
❐ Parent/Guardian of minor(s)
❐ Other (specify)________________________

Identify married woman's maiden name, names of minor children, Insured's name, or others to whom authorization applies.

________________________

## Replacement Information

To the best of your knowledge and belief, will insurance applied for replace insurance issued by this or any other company? ❐ Yes ❐ No
If "Yes," list all policies to be replaced: ________________________

Signature of Proposed Insured

Signature of Owner/Applicant if other than Proposed Insured

Signed at (City and State)  Date (month/day/year)

### Agent Signature

I hereby certify that I have truly and accurately recorded on this application the information supplied by the Applicant and/or Proposed Insured.

Signature of Agent  Date
Jerry Hill

| Agent Telephone No. | Fax | E-Mail Address |
|---|---|---|
| 800-926-9107 | 800-884-3086 | jerry@beneflexfinancial.com |

Please print all answers in ink.

**For Agent Use – Term Applications Only**

Proposed Insured ____________________ Policy Number ____________________

E-Mail Address ____________________

**Allocation of Production Credit - Please Print**

| | Agency or Agent Name(s) | Writing Code | Percent |
|---|---|---|---|
| 1st Agency | | | |
| 2nd Agency | | | |

**Paramedical Examiner Preference. Do not order the paramedical exam. This will be arranged upon completion of the interview.**

❒ APPS ❒ EMSI ❒ Portamedic ❒ Exam One ❒ HealthMasters

**Rates Quoted**

❒ Super Preferred ❒ Preferred ❒ Select Nonsmoker ❒ Nonsmoker ❒ Select Smoker ❒ Smoker

**Comments/Remarks** ____________________

Jerry Hill / 3789

**Instructions:**

1. **Fax both sides of completed form to: (513) 794-4581**
2. **Mail original form to: Underwriting Department, P. O. Box 5409, Cincinnati, Ohio 45201-5409**
3. **Do not order the paramedical exam. This will be arranged upon completion of the interview.**

Jerry Hill / 3789

Ohio National
Financial Services®
The Ohio National Life Insurance Company
Ohio National Life Assurance Corporation/Cincinnati

P.O. Box 237
Cincinnati, Ohio 45201-0237
(513) 794-6100

# Notice of Information Practices

One of the prime objectives of Ohio National is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure low cost, but also to assure that the fair share of the cost is contributed by each policyholder. Information from a number of sources is considered when we evaluate your application. We consider the results of your physical examination, if required, and any reports Ohio National may receive from doctors and hospitals who have attended you.

Information regarding your insurability and claims will be treated as confidential. Ohio National or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information it may have in its file.

The purpose of the MIB is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the MIB may alert the insurer to the possible need for further investigation. The MIB is not a repository of medical reports from hospitals and physicians, and information in the MIB file does not reveal whether applications for insurance are accepted, rated, or declined.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Telephone number (617) 426-3660.

When authorized by you, Ohio National or its reinsurers may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Furthermore, as part of the processing of your insurance application, we may request an investigative consumer report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your desire. You also have the right to receive a copy of the report and, by making a written request to Ohio National within a reasonable period of time, to receive additional, detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to ask about personal information which we may have in our files and the right to seek a correction of information you think is wrong.

Ask our agent for assistance, or write or call us at Ohio National, Attention: Underwriting Division, P.O. Box 237, Cincinnati, Ohio 45201-0237. Telephone (513) 794-6100.

Thank you for your application.

## Limited Temporary Life Insurance Agreement

Subject to the following limitations:

- **Not over $1 million of coverage for not more than 60 days**
- **No coverage for pre-existing conditions**

You will have limited temporary insurance if the following CONDITIONS are satisfied:

1. You truthfully complete and sign a full Application for life insurance and take any medical or paramedical exam we require; and
2. You pay the first monthly premium, or not less than 10% of the annual premium, for the policy for which you apply; and
3. You have not been diagnosed or treated for heart attack, stroke or cancer within the last two years; and
4. You have not been advised to have surgery which has not been performed; and
5. You are insurable; and
6. You are not over age 65.

The limited temporary insurance will be subject to all of the terms of this Agreement. Your payment must be in the form of a check, honored by your bank, or money order given with your Application. ALL CHECKS OR MONEY ORDERS MUST BE MADE PAYABLE TO "OHIO NATIONAL LIFE." DO NOT MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO THE AGENT. DO NOT LEAVE "THE PAYEE" BLANK.

If you answer question 5a in your full Application "Yes", or you leave it blank, then: (1) NO COVERAGE takes effect under this Agreement; and (2) we will return any payment made with this Application.

## Terms

**Scope of Coverage; Exclusions.** Your insurance under this Agreement is the same as if we had issued to you the policy you applied for, EXCEPT that (a) the amount of life insurance is limited as set forth below in this Agreement; and (b) your insurance does not include coverage under any Accidental Death Benefit Rider. You have NO COVERAGE at any time if: (1) death results from suicide while sane or by self-destruction while insane; or (2) death is proximately caused by a sickness or condition for which advice or treatment was given or recommended to you by a medical professional within one year prior to the date of your application; or (3) we find that you are not insurable on any basis under our underwriting rules and practices. No agent is authorized to approve coverage or to waive or change any of the provisions of this Agreement.

**Amount of Life Insurance** (Not over $1 million)**.** The amount of temporary life insurance provided by this Agreement is the LESSER of: (a) the amount you have applied for in your Application; or (b) the amount we will issue based on your income and assets according to our published rules; or (c) $1 million minus the amount of all other life insurance coverage you have with us.

**When Insurance Begins.** Your temporary coverage under this Agreement begins at the LATEST of: (a) the date of your Application; or (b) the date you complete any medical or paramedical exam required with your Application; or (c) the policy date requested in your Application.

**When Insurance Ends.** Your temporary coverage under this Agreement ends at the EARLIEST of: (a) 60 days after it begins, or (b) the date the insurance policy you applied for takes effect, or (c) the date we offer you a policy other than as applied for, or (d) the date we mail you notice that your coverage ends and enclose a refund of your payments to us. We reserve the right to end your coverage and refund your payment at any time.

**Changes in Your Health.** This Agreement does not commit us to issue the policy you have applied for or any other policy. However, if we can find, based on our underwriting rules and practices, that you were a standard risk for life insurance as of the date your coverage began under this Agreement, then: (a) we will act upon your Application without regard to any change in your health which occurs while this Agreement is in effect; and (b) we will offer you policy coverage in place of this Agreement to take effect the same date as insurance began under this Agreement. Any policy we offer may be different from the one you applied for. It may be reduced in amount according to our rules. If your health has changed, no life insurance policy will be issued for more than the amount of your temporary coverage under this Agreement.

**Premiums; Refunds.** The payment made to us with your Application will be applied to pay premiums due under any policy we issue to you. If we pay a claim under this Agreement but do not issue a policy, we will retain one month's premium. If no policy takes effect, and no claim is incurred, our only obligation is to refund your money. All refunds are without interest.

**Definitions.** The full Application to which this Agreement refers will be an Application completed by you at a date subsequent to the date your agent signs and delivers to you the RECEIPT below. The Application includes the health questions you answer as part of any required medical or paramedical exam. "You" or "your" means the proposed insured and/or applicant. "We," "our" or "us" means Ohio National Life, P.O. Box 237 Cincinnati, Ohio 45201-0237.

## Receipt

We acknowledge receipt of your payment as shown below and in Question 5 of the full Application.
PLEASE BE SURE TO READ THIS AGREEMENT CAREFULLY.

Amount Received

$

Date

Signature of Agent