



Chase Insurance Life and Annuity Company  
 Chase Insurance Life Company  
 Elgin, Illinois 60123-7836

Policy Number

<b>APPLICATION FOR INDIVIDUAL LIFE INSURANCE</b>			Amount remitted with this application, in exchange for the Company receipt: \$ Do not submit money if death benefit exceeds \$500,000.		
Proposed Primary Insured _____ Proposed Other Insured _____			Owner, if other than proposed insured (N/A for OIR)		
Name Last	First	MI	<input type="checkbox"/> Male	Owner's address	
			<input type="checkbox"/> Female		
Street					
City		State	Zip		
Social Security number		Occupation			
Birthplace		Birthdate	Age at nearest birthday		
Home phone ( )		Business phone ( )			
Where can you be reached for additional information? ___ Home ___ Work Best days: Best times: ___ a.m. ___ p.m.					
Initial death benefit (Specified amount, if UL) \$					
Rate class applied for:					
Plan of insurance:					
If UL/VUL*: (If neither is selected, Option A will be assigned.) <input type="checkbox"/> Option A: Specified amount includes cash value <input type="checkbox"/> Option B: Specified amount plus the cash value * If VUL, complete the VUL Supplement.					
Riders: ___ WP/WMD ___ OIR ___ Other: (complete separate application for each OIR)					
Planned periodic premium (UL/VUL only): \$					
Mode of premium payment: ___ Annual ___ SA ___ Qtrly ___ PAC ___ Quick Check					
Special Requests:					
<p><b>Authorization To Obtain And Disclose Information:</b> I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company checked above; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy.</p> <p>I (we) have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau.</p> <p>I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; and any other organization, institution or person that has any records or knowledge of me or my health, to give to the Chase Insurance companies, or their reinsurers or the Medical Information Bureau, any such information. This authorization is valid for two and one-half years from the date this form is signed. An exact copy of this authorization is as valid as the original.</p>					
Signed at: (city and state) _____			Signature of Proposed Insured (if age 18 or over) _____		
Date signed: (month/day/year) _____			Signature of Owner/Applicant, if other than Proposed Insured _____		
Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policy(ies)? (If "Yes," complete any required replacement forms.) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
Has the Owner been provided an illustration which conforms to this application? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for.					
Print General Agent's name/number			Print Agent's name/Social security number or Agent Code		
Agent's Signature		Date	Telephone number		

**Chase Insurance Life and Annuity Company**  
**Chase Insurance Life Company**

File number

the "Company"

2500 Westfield Drive • Elgin, Illinois 60123-7836

Telephone 847-930-7000

Print name of base policy Proposed Insured: \_\_\_\_\_

**Notice of Insurance Information Practices**

Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected may in certain circumstances be disclosed to third parties without your authorization. You may request to be interviewed in connection with the information being collected. A right of access and correction exists with respect to all personal information collected. A detailed explanation of our insurance information practices will be furnished to you upon your written request to our Underwriting Department.

**Fair Credit Reporting Act Notice**

As a part of our regular procedures, we may get a consumer report. The report will contain information about your character, general reputation, personal characteristics and mode of living. The information is obtained through interviews with your friends, neighbors, and associates. You have the right to ask for details on the nature and scope of this report. You have the right to contact the consumer reporting agency to review a copy of the report. If you write to us we will send you a written summary of your rights, and let you know: whether we have in fact obtained a report; and, if so, the name and address of the agency making the report.

**Medical Information Bureau Notice**

Information we obtain will be treated as confidential. We or our reinsurers may make a brief report to the Medical Information Bureau. The Bureau is a non-profit 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 submit a claim for benefits, 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 to disclose 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 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 in our file to those other life insurance companies to whom you may: apply for life or health insurance; or submit a claim for benefits.

**General Information Practices**

We may collect information from sources other than the individual(s) proposed for coverage. In certain circumstances we may give information we have gathered to third parties without your authorization. We disclose Medical Information Bureau information only to our reinsurers. Persons who are the subject of information we collect have the right to access and correction. If you write to us we will send you a detailed description of our information practices.

**This Notice must be given to the Proposed Insured before the application is completed.**

# Conditional Receipt

To:  **Chase Insurance Life and Annuity Company**

**Chase Insurance Life Company**

2500 Westfield Drive, Elgin, Illinois 60123-7836

— Do not complete and give to Applicant unless payment is made—

In exchange for the payment of the first required premium with the application, the Company selected above will provide insurance prior to policy delivery, under the following terms.

No insurance will be provided under this Receipt unless all requirements are first fulfilled exactly during the lifetime of the Proposed Insured. If all requirements are not so met, or the Proposed Insured dies by suicide, the liability of the Company shall be limited to a refund to the Applicant of the payment made for this Receipt. Medical requirements are defined by the Company's current rules and practices and include hospital and physician reports, and medical examinations and tests. No agent may alter or waive any part of this Receipt. This Receipt provides no insurance for riders or additional benefits.

## Requirements

The following must first be fulfilled for insurance to start:

- a. All medical requirements are completed and received by the Company within 60 days from the date of the application;
- b. The first premium has been paid in full;
- c. All questions in the application have been answered;
- d. All answers given in the application are true and complete; and
- e. The Proposed Insured is acceptable to the Company under its rules and practices, for the plan and amount applied for, without amendment, at the rate class applied for or a lesser premium, as of the date the Company receives all of its medical requirements.
- f. The Proposed Insured has complied with all parts of the Life Application.

## Start of Insurance

If the above requirements are first met, this Receipt will provide insurance beginning the latest of: (1) the date of the application; or (2) the date of receipt of all medical requirements by the Company.

## End of Insurance

Once begun, any insurance this Receipt may provide ends at the earliest of: (1) 60 days after the date of the application; (2) when the Company sends a refund of the premium which was exchanged for this Receipt; or, (3) the date any policy issued goes into effect.

## Amount Limit

The amount of insurance provided by this Receipt is the lesser of: (a) the initial death benefit of the insurance applied for in the application; or (b) \$500,000 less all amounts of life insurance and accidental death benefits applied for or in force with the Company and its affiliates.

## Payment Terms

The first premium will not be considered paid unless any check, draft, or other instrument of payment (given as premium) is paid in accordance with its terms. All premium checks must be made payable to the Company selected. Do not make checks payable to the Agent. Do not leave the payee blank.

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This Receipt is given on behalf of the company selected above.

I have read and agree to the above terms.

Dated \_\_\_\_\_ Signature of the Owner/Applicant \_\_\_\_\_

Received from \_\_\_\_\_ \$ \_\_\_\_\_

for coverage on \_\_\_\_\_ (the Proposed Insured)

Dated \_\_\_\_\_ Signature of Agent/Witness \_\_\_\_\_