

Confidential Personal and Insurance Information

After receiving the following three pages of information, Wilbanks & Associates will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign pages two and three. **For joint survivor policies please complete sections 1 and 3 for both insured's on a separate form, and have releases signed by both insured's. Medical, financial or other personal information that you provide will only be used to obtain an offer for your policy.**

1. Personal Data

Name of Insured: _____ Social Security #: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number(s): Daytime () _____ Evening () _____

Date of Birth: _____ Marital Status: _____ Sex: Male Female

Dependent Children: Yes No Smoking status: Smoker Non smoker

Are you currently employed? Yes No If No, date last worked _____.

If policy owner is different than above

Name of policy owner: _____ SS/Tax ID #: _____

Current Address: _____ Date of birth _____

City: _____ State: _____ Zip Code: _____

Telephone Number(s): Daytime () _____ Evening () _____

2. Life Insurance Policy Information

(Please enclose a copy of the policy and complete the following)

Policy #1

Name of Insurance Company: _____

Policy Number: _____ Date Policy was Issued: _____

Coverage/Face Amount: \$ _____ Cash Surrender Value: \$ _____

Annual Premium: \$ _____ Assignments, loans or liens? _____

Type of Policy: Term Whole Life Universal Life Other _____

Individual Group Joint Survivor Policy issued: Standard Rated _____

Policy #2

Name of Insurance Company: _____

Policy Number: _____ Date Policy was Issued: _____

Coverage/Face Amount: \$ _____ Cash Surrender Value: \$ _____

Annual Premium: \$ _____ Assignments, loans or liens? _____

Type of Policy: Term Whole Life Universal Life Other _____

Individual Group Joint Survivor Policy issued: Standard Rated _____

3. Medical History

Please give a brief description of your medical condition: _____

Name of Physician seen for this medical condition:

Name of Physician: _____

Address: _____ Telephone: () _____

City: _____ State: _____ Zip: _____ Date last seen _____

Who is your primary or family physician? (if different than above)

Name of Physician: _____

Address: _____ Telephone: () _____

City: _____ State: _____ Zip: _____ Date last seen _____

If there are any other physicians that have treated you in the last three years, you may attach an additional page including their full name, address, and telephone.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signature of Policy Owner

Printed Name

Date

AUTHORIZATION

Please include this authorization to release records and policy information with this application.

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an "Authorized Discloser") to provide Wilbanks & Associates and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representative ("Wilbanks"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Wilbanks the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Wilbanks in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Wilbanks with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser to Wilbanks may be redisclosed by Wilbanks and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained in this Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

AUTHORIZED DISCLOSERS:

Name of Insured Signature of Insured Date

Date of Birth Social Security Number

Name of Witness Signature of Witness Date

Name of Owner (If other than Insured) Signature of Owner (if other than Insured) Date

Name of Witness Signature of Witness Date

To facilitate execution, this application may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart hereof, and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.