EQUIS
APPLICATION PACK

GPM Life

Final Expense

Indiana

IMPORTANT REMINDER: ALL APPLICATIONS MUST BE UPLOADED TO EQUIS FINANCIAL USING THE AGENT DASHBOARD. PLEASE DO NOT SEND APPLICATIONS DIRECT TO THE CARRIER.

Form Name	*When Do You Need To Complete This Form*
Final Expense App for Ages 50 - 85:	**Always Required**
HIPAA Authorization Form HIPAA-0123:	**Always Required:** Authorizes the release of medical information by physicians, health care professionals, hospitals, clinics, medical facilities, or other health care providers.
In Preparation for your Personal History Interview (PHI):	**Always Required:** A personal history interview is required for all final expense applicants.
Bank Draft Authorization (EFT):	**Always Required:** Used to set up bank draft of premium payments. Requires a voided check be included.
EFT Supplement:	*Only Required If* applicant is unable to include a voided check with the bank draft authorization.
Replacement Notice Form:	*Only Required If* applicant is replacing insurance.
GPM Understanding of Policy Replacement Form:	*Only Required If* applicant is replacing insurance.
CIR (Child Insurance Rider) Supplemental Application:	*Only Required If* the applicant wants to add the child insurance rider to the proposed policy.
Final Expense Application Certificate:	*To Be Left With Client:* Form that congratulates the applicant on applying for life insurance and informs them of the personal history interview process. It gives them the contact information and hours of operation for the interview staff. It also provides a place for the agent to put their information.

Notes: ***Apps and disclosures must be printed single-sided only.***
It is recommended that the client call GPM to complete the personal history interview while the agent is taking the application. If that is not possible, then the agent can leave the PHI page with the client. As soon as GPM receives the application, if the personal history interview hasn't been completed, that dept. will begin to make outbound phone calls to get ahold of the client and complete the interview.

DISCARD THIS COVER SHEET - DO NOT SUBMIT COVER SHEET WITH COMPLETED APP

APPLICATION FOR INDIVIDUAL LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222

www.gpmlife.com

For Ages 50 through 85, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1. Name of Proposed Insured (First, M.I., Last)

2. Gender ❑ Male ❑ Female 3. Date of Birth 4. Place of Birth

5. Proposed Insured's Occupation

6. US Citizen ❑ Yes ❑ No 7. Social Security # 8. Height 9 Weight

10. Home Address of Proposed Insured City State/Country Zip

Primary Telephone Number: E-mail:

Best time to call ________ A.M. ________ P.M. Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

11. Policy: WHOLE LIFE POLICIES

LEVEL DEATH BENEFIT
☐ LIFETIME PAY ☐ 10 PAY ☐ 20 PAY
☐ Accidental Death Benefit
☐ $5,000 Child Insurance Rider (Part 2 Required)

☐ GRADED DEATH BENEFIT
30% 1st Year, 70% 2nd Year
Lifetime Pay

☐ MODIFIED DEATH BENEFIT
First 2 Years: Return of Premium + 10% interest
Lifetime Pay

12. Amount Applied for:$ 13. Premium Amount: $

14. Premium Mode: Direct Bill: ❑ Annual ❑ Semi-Annual (~~❑ Quarterly~~ no longer available)
Automatic Draft/EFT: ❑ Monthly

15. Automatic Premium Loan (if available) ❑ Yes ❑ No

16. Beneficiary(ies) Name (First M.I., Last) Address (City, State/Country, Zip) Date of Birth Social Security # Relationship

Primary (Class 1) ______

Contingent (Class 2)

*All beneficiaries in a class shall share equally, or to the survivor. Proceeds pass to Class 2 beneficiaries only if no one in Class 1 survives.

17. Owner/Applicant, if other than the Proposed Insured: Name ______

Social Security # ______ Relationship to Proposed Insured ______ DOB ______

Address:

18. Physicians' names, addresses and phone numbers: ______

19. a. Life insurance policy or annuity contract in force on All Proposed Insureds: ❑ None ❑ Listed below

Insured	Issue Year	Company	Face Amount	ADB Amount

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? . . . . ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form including any nicotine product in the past 12 months? . . . . ❑ Yes ❑ No

If any question from 21 through 27 is answered "Yes", do not complete or submit. If any question from 28 through 30 is answered "Yes", the Proposed Insured may be eligible for Modified Benefit Whole Life: Full Death benefit for accidental death; return of premiums for non-accidental death during the first two years. If any question from 31 through 35 is answered "Yes", the Proposed Insured may be eligible for Graded Death Benefit: Full death benefit for accidental death; limited death benefit for non-accidental death during the first two years and full death benefit thereafter. If questions 21 through 35 are correctly answered "No", the Proposed Insured may be eligible for Level Whole Life (Full Death Benefit).

YES NO

21. Has the Proposed Insured been told by a physician that s(he) has less than 12 months to live? ❑ ❑
22. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care or kidney dialysis? ❑ ❑
23. Has the Proposed Insured been diagnosed by a physician as having Alzheimer's Disease, dementia, Amyotrophic Lateral Sclerosis (ALS) or been prescribed any of the following medications: [Donepezil (Aricept), Memantine (Namenda), Rivastigmine (Exelon), Galantamine (Razadyne), Tacrine (Cognex)]? ❑ ❑

YES NO

24. Has the Proposed Insured ever been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus? ❑ ❑
25. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure (CHF) or cardiomyopathy? ❑ ❑
26. During the past 5 years, has the Proposed Insured been convicted of a felony or misdemeanor, or been on parole or probation for any offense? ❑ ❑
27. Is the Proposed Insured currently diagnosed by a medical professional as having or being treated by a medical professional for melanoma, internal cancer, leukemia, or Hodgkin's disease? ❑ ❑

YES NO

28. During the past 4 years, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for Melanoma, internal cancer, leukemia, or Hodgkin's disease? ❑ ❑
29. Is the Proposed Insured currently receiving or has (s)he been recommended to receive oxygen? ❑ ❑

YES NO

30. Does the Proposed Insured need any assistance performing Activities of Daily Living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices? ❑ ❑

YES NO

31. During the past 12 months, has the Proposed Insured:
    a. Been admitted to or confined in a hospital two or more times? ❑ ❑
    b. Been told by a medical professional that (s) he needs a medical procedure, diagnostic test (excluding tests related to the Human Immunodeficiency Virus (AIDS Virus)), surgery, hospitalization or nursing facility care that has not been completed? ❑ ❑
    c. Been confined to a nursing facility or received home health care? ❑ ❑
32. During the past 24 months, has the Proposed Insured been treated by, diagnosed by or given medical advice by a medical professional, including office visits, medications or surgery for:
    a. Stroke, Transient Ischemic Attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain? ❑ ❑
    b. Organ transplant, or recommendation to have an organ transplant? ❑ ❑
    c. Parkinson's Disease, seizure, neurological disorder, major depression, schizophrenia, psychosis, Bipolar Disorder, or other psychiatric disorder? ❑ ❑

YES NO

    d. Liver disease, kidney disease, pancreatic disease, kidney failure or lupus (SLE)? ❑ ❑
    e. Irregular heart rhythm, enlarged heart, or any other heart disorder? ❑ ❑
    f. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars? ❑ ❑
    g. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)? ❑ ❑
33. During the past 24 months, has the Proposed Insured used any illegal drug or been treated by or given medical advice by a medical professional, including office visits, medications or surgery for alcohol and/or drug abuse? ❑ ❑
34. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations? ❑ ❑

35. Has the applicant, Proposed Insured, Proposed Owner or Proposed Beneficiary:

a. entered into, or planned to enter into, any agreement to sell any interest in
   i) the policy applied for, or
   ii) any other life insurance policy? .... ❑ YES ❑ NO

b. received, or been promised any inducement, fee, compensation, or loan as an incentive to
   i) the policy applied for, or
   ii) any other life insurance policy? .... ❑ YES ❑ NO

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance or annuity policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

36. If the policy I have applied for is not issued, please issue the policy I qualify for, if any, with:

❑ The same premium with a lower face amount. ❑ The same face amount with a higher premium.

I Understand that Accidental Death Benefit Rider and Child Insurance Rider are only available with the Level Policy.

(Proposed insured's initials required: ___________________________)

Details to any "Yes" answers: Indicate question number, condition, treatment, diagnosis date.

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written to the best of my knowledge and belief. I understand that any misrepresentation, inaccuracy, or incompleteness in an answer to any question about health condition, physical condition, or other question relating to insurability, which is material to any risk assumed, may cause any policy issued to become void during the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, or elected under section 36, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. **The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.**

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, MIB, Inc., government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I authorize Government Personnel Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I further authorize all said sources, except MIB, Inc., to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), MIB, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy and/or an electronic copy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "MIB, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement 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.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and MIB, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID ____________________
(REQUIRED)

To the best of your knowledge: Yes No

A. Does any Proposed Insured have any existing life insurance or annuity policy or contract? . . . . ❑ ❑

B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract? . . . . ❑ ❑
If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X______________________ ____________ ______/______ ______________________ ________%
Writing Agent's Signature Date State / License # GPM Life Agent #

______________________ Split Agent GPM Life # ______________________ ________%
Writing Agent's Name (Please Print)

RECEIPT FOR PAYMENT

Received from ____ Date ____________________

the sum of $ ____________________. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. **The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.**

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MIB, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MIB, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to MIB, Inc., 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 a claim for benefits is submitted to such a company, 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 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 Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

To Government Personnel Mutual Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

____ Date of Birth ____________________
Name of proposed insured/patient (please print)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, 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, pharmacy records, and any other protected health information concerning me to the Government Personnel Mutual Life Insurance Company (GPM Life) and its agents, employees, and representatives. 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.

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 GPM Life 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 GPM Life.

This authorization shall remain in force for 30 months following the date of my signature below. 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 sending a written request for revocation to GPM Life at 2211 N. E. Loop 410, San Antonio, Texas 78217, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that GPM Life 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 may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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, GPM Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____ ________________________
Signature of Proposed Insured/Patient or Personal Representative Date

____
Description of Personal Representative's Authority or Relationship to Patient

See Reverse Side for Common Questions About this Authorization

Common Questions and Answers about Release of Protected Health Information to a Life or Disability Income Insurer

1. **What is HIPAA?**

   HIPAA is the Health Insurance Portability and Accountability Act of 1996. Its Privacy Rules require, in part, that health care providers receive a signed, written authorization meeting HIPAA's requirements before releasing to others Protected Health Information pertaining to the signer.

2. **May I release complete personal medical information to a life or disability income insurance company?**

   Yes. As you did before the HIPAA Privacy Rule became effective, a medical care provider may disclose complete Protected Health Information to organizations not subject to the Privacy Rule as long as the applicant has signed a HIPAA compliant authorization.

3. **Does the minimum amount necessary rule apply to this release to a life or disability income insurer?**

   No. The minimum necessary rule does not apply as long as a HIPAA compliant authorization is signed. This question was specifically addressed by HHS in a Q&A published December 4, 2002. This information may be found at www.hhs.gov/ocr/hipaa.

4. **Can an insurer request disclosure of a person's "entire" medical record?**

   Yes. HIPAA allows insurers to seek and providers to disclose a person's entire medical record, if the authorization used clearly states that the entire medical record is to be disclosed (e.g., "I authorize you to disclose my entire medical record.")

5. **Does HIPAA mandate the use of one specified form of authorization by everyone?**

   No. HIPAA requires that certain specified "elements" be included in a valid authorization to disclose protected health information. HIPAA does not mandate that a specific form be used. Both covered and non-covered entities are free to use any format they wish so long as it is compliant with HIPAA's requirements. The attached signed authorization contains all of the elements required by HIPAA.

6. **What should I do if I have previously agreed to a restriction and now receive an authorization to release the "entire medical record." Does the attached authorization cover PHI that was restricted?**

   You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of the enclosed authorization specifically releases any restricted information.

To Government Personnel Mutual Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

____ Date of Birth __________________
Name of proposed insured/patient (please print)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, 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, pharmacy records, and any other protected health information concerning me to the Government Personnel Mutual Life Insurance Company (GPM Life) and its agents, employees, and representatives. 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.

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This protected health information is to be disclosed under this Authorization so that GPM Life 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 GPM Life.

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   You may release all medical records, restricted and otherwise if a patient has previously requested a restriction and later signs an authorization which removes the restriction. The wording of the enclosed authorization specifically releases any restricted information.

Thank You For Your Final Expense Application With GPM Life Insurance Co.

In preparation for your Personal History Interview (PHI) telephone call, please have the following information available:

- Name, address and phone number for **ALL** doctors and clinics

  ____
  ____
  ____
  ____

- Date, doctor's name, and reason of last doctor's visit

  ____
  ____
  ____

- Name and dosage for **ALL** prescribed medications

  ____
  ____
  ____

- Name, address and phone number for **ANY** hospital admission

  ____
  ____
  ____

- Age and cause of death of all immediate family members

  ____
  ____
  ____

- If any immediate family member had heart disease, stroke or diabetes prior to their age 60, provide data ____________________

  ____
  ____

- **Your Agent is:____________________ Agent's Number:____________________**

1 (888) 476-5433

PHI Interview Hours of Operation

Monday & Wednesday:	**8:00 AM – 7:00 PM Central Time**
Tuesday & Thursday:	**8:00 AM – 5:45 PM Central Time**
Friday:	**8:00 AM – 2:00 PM Central Time**

Government Personnel Mutual Life Insurance Company

2211 NE Loop 410, San Antonio, TX 78217 (800) 938-4765 www.gpmlife.com

AUTHORIZATION TO HONOR WITHDRAWALS REQUESTED BY GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

P.O. Box 659567, San Antonio, Texas 78265-9567
(210) 357-2222   Fax (888) 701-3869   (800) 929-4765

– – DEPOSITOR MUST COMPLETE ALL INFORMATION – –

Premium Payor ____
(Print name as shown on bank records.)

Bank/Branch ____ ❑ Checking ❑ Savings

Bank Mailing Address ____
(COMPLETE ADDRESS AND ZIP CODE OF BANK OR BRANCH WHERE ACCOUNT IS MAINTAINED.)

As a convenience to me, I hereby request and authorize you to pay and charge to my account withdrawals requested by GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such requests.

I agree that your treatment of each such request, and your rights in respect to it, shall be the same as if it were signed personally by me. I further agree that if any such request be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

The GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY is instructed to forward this authorization to you, as required.

____________________ ____
Date Signature of Depositor as shown on Bank Records for account to which this Authorization applies.

Please sign and return with a voided check or deposit slip for bank information.

For new policies only, choose from these policy dates 1st through 28th: Please specify day: __________

Existing policies will be drafted on due dates. Policy number: ______________________________

INDEMNIFICATION AGREEMENT

TO: BANK NAMED ABOVE

In consideration of your compliance with the request of the Government Personnel Mutual Life Insurance Company, hereinafter called the Insurance Company, and the depositor on whose account withdrawals will be made, the Insurance Company agrees, subject to the limitation in paragraph (5):

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

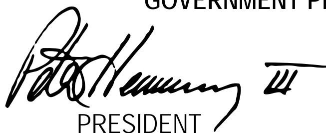
(2) In the event that any such check, draft or order shall be dishonored, whether with or without cause and whether intentionally or inadvertently, to indemnify you and hold you harmless for any loss even though dishonor results in a forfeiture of insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

(4) Your participation in this plan may be terminated by 30 days written notice to the Insurance Company and the premium payor.

(5) In the case of EFT (electronic funds transfer) or ACH (automated clearing house) methods of collecting premiums, the above shall be modified to provide the named bank no more indemnification than is required by The National Automated Clearing House rules and any applicable local Automated Clearing House rules.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY


PRESIDENT

SECRETARY

Authorized in a resolution adopted by the Board of Directors of the Government Personnel Mutual Life Insurance Company on October 2, 1991.

INFORMATION FOR ELECTRONIC FUNDS TRANSFER (EFT) PREMIUMS FROM SAVINGS ACCOUNTS OR NON-TRANSACTIONAL ACCOUNTS

I request that GPM Life use the following bank transit routing and account numbers for EFT premium payments on the applications and/or policies listed below.

Account Owner: ____

Bank Name and Branch Address: ______________________________________

Bank Contact (Not Required) and Phone Number: ___________________________

Bank Transit Routing Number: ______________________________________

Account Number: ____

Policy Number	Insured Name

- ✓ A voided check is not available for my account.
- ✓ A preprinted deposit slip with my bank's transit routing and my account number is not available.
- ✓ I understand premiums will not be paid if drafting instructions are not accurate or not honored.
- ✓ I have signed and attached an authorization to honor withdrawals requested by GPM Life.

_______________________ ____________________________________
Date **Signature of Policy Owner**

_______________________ ____________________________________
Date **Signature of Premium Payor, if different**

Agent's Statement: I have verified the account information and bank transit routing number shown above as complete and accurate.

_______________________ ________________________ ____________
Date **Agent's Signature** **Agent Number**

Government Personnel Mutual Life Insurance Company (GPM Life)
P.O. Box 659567, San Antonio, TX 78265-9567
Phone: (800) 929-4765 or (210) 357-2222 ● Fax: (888) 701-3869

Government Personnel Mutual Life Insurance Company
GPM Life Building, 2211 N. E. Loop 410, San Antonio, Texas 78217
P. O. Box 659567, San Antonio, Texas 78265-9567
1-800-929-4765

EXHIBIT A

IMPORTANT NOTICE REGARDING
REPLACEMENT OF LIFE INSURANCE

If you are thinking about DISCONTINUING or CHANGING an existing policy or annuity contract and BUYING a replacement, your decision could be a good one -or possibly a mistake. Make sure you understand the facts. You should

- Make a careful comparison of your existing policy and the proposed policy.

- Ask the company or agent that sold your existing policy to provide you with complete information about it.

- Consider both sides before you decide.

- Determine what you want your insurance program to do.

- Consider your present health. You may have had a change which could affect your insurability, so make sure to continue your present policy until a new policy is delivered to you and accepted by you.

This form MUST be completed in triplicate and the original given to you by the agent proposing the replacement no later than at the time you apply for the new policy. (This form must be completed and given to you even though the proposed replacement policy is with the same company that sold you your existing policy.)

EXISTING POLICY INFORMATION on ______________________________
(Name of Insured)

COMPANY	TYPE OF POLICY	POLICY NO.	DATE OF ISSUE	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

(If more policies are involved, used additional sets of forms)

PROPOSED POLICY INFORMATION on ______________________________
(Name of Insured)

COMPANY	TYPE OF POLICY	FACE AMOUNT OF BASIC POLICY	TYPE OF OPTIONAL BENEFITS

Indiana Department of Insurance Regulation 760 IAC 1-16.1 requires that the company making the company making the replacement notify your existing insurance company that you may be replacing your existing policy. (You have the right, within twenty days after delivery of a replacement policy, to return it to the company and to claim an unconditional refund of all premiums paid on it.)

____
Applicant's Signature

____
Date

____
Replacing Agent's Signature

____
Address

____
Telephone Number

____
Indiana License Number

Understanding of Policy Replacement

(Complete this form when replacement of an existing life insurance policy or annuity contract is intended in purchasing a new insurance policy or annuity contract. Use this Form only in states where no version of the NAIC Model Replacement Regulation is in effect. Contact the Home Office for more information.)

Applicant Name: ______________________________

Address: ______________________________

____

Home Phone: ______________________________

Work Phone: ______________________________

1. This replacement is being made at the
   ___ Request of the Policyholder
   ___ Recommendation of the Agent

2. How will the existing policy or contract be impacted because of the replacement? ______________________________

   ____

3. Was the current policy or contract information (like an annual statement) used in the decision to replace the existing policy or contract?
   ___ Yes (enclose current information with this form)
   ___ No (If "No", why not? ______________________________)

4. The existing policy or contract is being replaced because:

   ____
   ____
   ____
   ____
   ____
   ____
   ____

I understand that I am applying for a new life insurance policy or annuity contract, as shown on the attached application. I have read the "Notice" and "Items to Consider" shown on the back of this form. If this policy or contract is issued, I may be withdrawing funds from my existing policy or contract (note by company and policy number) ______________________________in the form of a (surrender, loan, dividend withdrawal) to fund the new policy. I consent to this action, as I deem it to be an appropriate method of funding my new policy or contract.

Signature of Applicant	Date	Signature of Agent	Date
		Printed Name of Agent	Agent Number

Government Personnel Mutual Life Insurance Company
P O Box 659567, San Antonio, Texas 78265-9567
210-357-2222 or Toll Free 800-929-4765

NOTICE

ASK QUESTIONS - IT'S YOUR MONEY - GET THE FACTS

Whether it is to your advantage to replace or change your existing insurance policy or annuity contract, only you can decide. It is in your benefit to obtain adequate information in order to compare relatively short and long-range costs and benefits before a final decision is made.

1. Due to a possible change in insurability status (health, occupation or high-risk activities) you might be denied new coverage, or the premium may be higher than a standard premium.
2. The incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your present insurance company may be able to modify your existing plan on terms which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. REMEMBER: Following receipt of a new life insurance policy or annuity contract you should immediately examine its contents. If you are not satisfied with it for any reason, you have the right to return it within the free look period (as shown on the policy face page) to the insurer at its home or branch office or the agent through whom it was purchased. In return, you will be entitled to a full refund of premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

NOTICE TO AGENTS
POSSIBLE FACTORS TO DISCUSS WITH APPLICANT PRIOR TO REPLACING

A policy or contract should only be replaced after a determination that replacement is in the best interest of the policyholder/ applicant. Information on the existing policy or contract should be obtained and compared to any possible new policy or contract, with consideration given to the following:

Premiums — How do premiums compare between the two policies or contracts? Is one policy more affordable than the other policy? Will one policy require premiums to be paid for a longer period of time than the other policy?

Policy Values — Policy acquisition costs will have to be paid a second time when replacing an existing policy. Incurring these costs a second time will have a negative impact on policy values. Does the new policy or contract outperform the existing one in spite of the occurrence of these acquisition costs? Does the new policy or contract outperform the existing one on the basis of both guaranteed and non-guaranteed policy value accumulation? Compare surrender charges between the new policy or contract and the existing one.

Insurability — If the applicant's health has changed since they bought the existing policy, the new policy could cost more or the applicant could be declined for new insurance. The applicant may need to take a medical examination in order to obtain coverage under a new policy or contract. Claims on most new policies **for up to the first two years** can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

Other Considerations — Are there any possible tax ramifications of replacing than old policy or contract with a new one? Are there any outstanding loans on the existing policy that would serve to reduce benefits? Is there potential for any tax-free exchange of policy values? Does the quality and financial stability of the new company compare with that of the existing company?

All of the above mentioned items could serve as material factors to be considered before any recommendation to replace existing coverage is made. Any or all of the above factors can assist the agent in providing specific, relevant answers to the Understanding of Policy Replacement Form.

Government Personnel Mutual Life Insurance Company
2211 N.E. Loop 410, San Antonio, Texas 78217

PART 2 - (Available only on Simplified Issue Whole Life Base policies of $5,000 and over)
CHILD INSURANCE RIDER SUPPLEMENTAL APPLICATION
$5,000 DEATH BENEFIT PER CHILD FOR CHILDREN OR GRANDCHILDREN OF PROPOSED INSURED

(Each Proposed Insured Child must reside in the household of the Proposed Insured.)

ISSUE AGES 15 DAYS – 17 YEARS INCLUSIVE

PROPOSED INSURED CHILD'S				
Name *(First, Middle, Last)*	**Date of Birth**	**Age Last Birthday**	**US Citizen (Yes/No)**	**Relationship to Proposed Insured**

Health Statement. In the past 24 months, has the Proposed Insured Child/Children listed above, been diagnosed with, treated for, tested positive for, or been told by a medical professional they have: any form of cancer or leukemia; heart or circulatory disorder; cystic fibrosis; kidney disease; liver disease; diabetes; quadriplegia; multiple sclerosis (MS); seizures; muscular dystrophy; sickle cell anemia; cerebral palsy, autism or cognitive or psychological disorder, chronic respiratory disorder (excluding mild asthma with occasional inhaler use); or attempted suicide? ☐ Yes ☐ No

In the past 24 months, has the Proposed Insured Child/Children listed above, used any illegal, restricted or controlled substance except as prescribed by a medical professional. And have not been counseled or treated for alcohol or substance abuse or been convicted of a felony, or misdemeanor, or been subject to probation? ☐ Yes ☐ No

Details to any "Yes" answers: (Please note the child's name.)

____

____

I, the Proposed Insured from Part 1, am the parent or grandparent (if legal guardian please attach a copy of guardianship papers) of the Proposed Insured Child/Children and I have read the completed supplemental application. The above representations are true complete and correctly written to the best of my knowledge and belief. I understand that all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the rider incontestability provision. I agree that this supplemental application will become a part of any contract of insurance issued as a result of this application.

The Fraud Warning required in the State in which the Application for Life Insurance – Part 1 was signed and dated applies to this Part 2 – Child Insurance Rider Supplemental Application.

________________ ______________________________ ______________________________
Date Print Name of Proposed Insured from Part 1 Signature of Proposed Insured from Part 1

For Each Proposed Insured Child age 15 and Over			
Print Name	Signature	Print Name	Signature

________________ ______________________________ ______/____________ ____________________ _________%
Date Agent's Name (please print) State / License # GPM Life Agent #

______________________________ Split Agent GPM Life # ____________________ _________%
Writing Agent's Signature

Congratulations. . .

on making the decision to provide your family with the financial security afforded by permanent Life Insurance.

The Life Insurance policy for which you have just applied is called SECURE-Mark. It is either a Simplified Issue Whole Life policy (Form ICC13 70H SIW13), a Graded Death Benefit Whole Life policy (Form ICC13 70G GDB13), or a Modified Benefit Whole Life policy (Form ICC13 70I MBWL13), underwritten by Government Personnel Mutual Life Insurance Company (GPM Life) of San Antonio, Texas.

Please be aware that an employee from our home office will call you to clarify the answers you provided on the application, as necessary. This is called a Personal History Interview or PHI. Most often the call will be the next business day after you completed the application and takes only a few minutes of your time. Most of our applicants qualify for coverage. We'll let you know very soon if you do.

Occasionally, we won't be able to reach you when we call, so, if it's easier for you, feel free to telephone us on the second following day to help expedite the timely issue and delivery of your policy. This Toll-Free line is available for your use:

(888) 476-5433

Monday and Wednesday	8:00 AM	to	7:00 PM Central
Tuesday and Thursday	8:00 AM	to	5:45 PM Central
Friday	8:00 AM	to	2:00 PM Central

Your GPM Life Agent is: ______________________________

Your Agent's Phone # is: ______________________________

Government Personnel Mutual Life Insurance Company (GPM Life)

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PO Box 659567, San Antonio, TX 78265 • 2211 NE Loop 410, San Antonio, TX 78217

Toll Free: 800-938-4765 Local: 210-357-2222 Fax: 888-305-4111

www.gpmlife.com