TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

SOLUTIONS Series 121

Application/Forms Packet For: GEORGIA STATE UNIVERSITY

Marketed by: Jeff Trinkwon

FOR USE ONLY IN

Georgia

TEXASLIFE INSURANCE COMPANY

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INDIVIDUAL LIFE INSURANCE APPLICATION

FOR HOME OFFICE USE ONLY

1st Deduction Date: ________ **Employer**: ________ Policy Number: ________

Employee (EE)		Hire Date:		*Plan: SOLUTIONS Series 121*	
Last Name		First Name	MI:	Face Amount[2]	
SSN	Sex	Birth Date	Age[1]	**Premium**	**$**

Home Address: ________ City: ________ State: ________ Zip: ________

Phone-Day: Evening: Personal E-mail:

Tier 1	**Within the last 12 months have you used tobacco in any form?** .... **Yes** ☐ **No** ☐
	Are you at work on a full-time basis, performing your usual duties? .... **Yes** ☐ **No** ☐

(Spouse is beneficiary unless otherwise stated here) Name: Relationship:

☐ On all policies I elect the Automatic Contract Loan provision to pay a premium overdue 30 days or more, if the policy has sufficient cash value.

Riders: Included in Plan Premium	**Optional Riders: Additional Premium Required**
Accidental Death[(3)] ☐ Waiver Premium[(3)] ☐	Child Term rider - Add to policy of: Employee ☐ Spouse ☐ Rider ☐
Union Strike[(4)] ☐ Rider ☐	Family Term Rider[(4)] ☐ Total Premium of Optional Riders: **$**

Spouse (SP)				*Plan: SOLUTIONS Series 121*	
Last Name		First Name	MI:	Face Amount[2]	
SSN	Sex	Birth Date	Age[1]	**Premium**	**$**

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? .... **Yes** ☐ **No** ☐

(Employee is beneficiary unless otherwise stated here) Name: Relationship:

Dependents (DEP)				*Plan: SOLUTIONS Series 121*	
(1) Last Name		First Name	MI:	Face Amount[2]	
SSN	Sex	Birth Date	Age[1]	**Premium**	**$**

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? .... **Yes** ☐ **No** ☐

(Employee is beneficiary unless otherwise stated here) Name: Relationship:

(2) Last Name		First Name	MI:	Face Amount[2]	
SSN	Sex	Birth Date	Age[1]	**Premium**	**$**

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? .... **Yes** ☐ **No** ☐

(Employee is beneficiary unless otherwise stated here) Name: Relationship:

(3) Last Name		First Name	MI:	Face Amount[2]	
SSN	Sex	Birth Date	Age[1]	**Premium**	**$**

Within the last 12 months has the proposed insured age 17 or older used tobacco in any form? .... **Yes** ☐ **No** ☐

(Employee is beneficiary unless otherwise stated here) Name: Relationship:

Payroll is per: Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Skip ☐ ________ Total of all **Premiums: $**

Tier 2 (If answered "Yes" no coverage is offered, except as available under Tier 1 Questions)

During the last 24 months has the proposed insured been treated for, been prescribed medication for, or been diagnosed by a member of the medical profession as having, any of the following: **Answer(s):**

(a) Cancer (excluding non-melanoma skin cancer)?
(b) Heart attack, coronary artery or valve disease, heart failure or cardiomyopathy?
(c) Alcohol or drug abuse?
(d) Diabetes for which the recommended treatment is insulin?
(e) Chronic obstructive pulmonary disease (COPD), emphysema or other chronic lung disease (excluding asthma)?
(f) Stroke or transient ischemic attack (TIA)?
(g) Chronic kidney disease or kidney failure (excluding kidney stones)?
(h) Parkinson's disease or paralysis?
(i) Cirrhosis of the liver or hepatitis (excluding Hepatitis A)?
(j) Acquired Immune Deficiency Syndrome or tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies?

Employee	Yes ☐	No ☐
Spouse	Yes ☐	No ☐
Dep 1	Yes ☐	No ☐
Dep 2	Yes ☐	No ☐
Dep 3	Yes ☐	No ☐

[1] Age on Issue Date [2] or Face Amount purchased by premium shown, if less [3] Proposed insured issue ages 17-59 [4] EE Only

Will proposed coverage replace or change any existing insurance or annuity policy? Yes ☐ No ☐
(if "Yes" identify and complete replacement form.) Company ______________ Policy Number ______________
Do you have existing insurance or annuities (including coverage with Texas Life)? Yes ☐ No ☐ If "Yes" complete the Existing Insurance Form *even if replacement is not contemplated.*

For residents of IN, LA, KS, MA, MI, MS, NC, OH, OK, VA, and WA: I received a summary description of the accelerated death benefit and Important Notice regarding Accelerated Death Benefit.
For residents of ME, NH, WA, and WI: I acknowledge receipt of a Life Insurance Buyer's Guide.
For residents of Massachusetts: I acknowledge receipt of the Disclosure Regarding Right to Notice of Adverse Underwriting Decision Form [03M019MA] and the Massachusetts Electronic Signature Disclosure Form [05M117 (for applications taken with an electronic signature).
For residents of Pennsylvania: I acknowledge receipt of the Disclosure Notice for Accelerated Death Benefit Due to Terminal Illness Form [08M003PA]
For residents of West Virginia: I acknowledge receipt of the Agent Written Proposal Form [04M013] and discussed with the agent the insurance need and ability to pay the premium, and believe the insurance applied for is suitable.

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the the proposed insured. Insurance is effective under the policy only when it is delivered to the owner and the full first premium is paid in cash. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Insured
(Owner) Signature: ______________________________

City: ______________ State: __________ Date: __________

Agent Only: To the best of my knowledge the insurance applied for ☐ **is** ☐ **is not** to replace existing insurance or annuity. I have delivered to the Proposed Insured the applicable forms and information described in Additional Statements above.

Print Enroller Name: ______________________ Agent #: __________

Enroller Signature: ______________________ Date: __________

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SUPPLEMENT TO APPLICATION

Supplement to Application from (Employee): ____________________

Employee Social Security: ____________ **Application Date:** ____________

1. **Within the past five years, has any proposed insured:**	Employee		Spouse		Dep(s)	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
a. been treated by a member of the medical profession, been an inpatient or outpatient at a hospital or clinic, or been advised to have a surgical operation?	☐	☐	☐	☐	☐	☐
b. Had an X-ray, EKG, lab test, blood test, or any other medical test or study, except those related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐	☐	☐	☐	☐
c. Used heroin, cocaine, marijuana, PCP, or any other narcotic, hallucinogenic, sedative or legally controlled substance, except as prescribed by a physician?	☐	☐	☐	☐	☐	☐
d. Been diagnosed or treated by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or the HIV (Human Immunodeficiency Virus) infection?	☐	☐	☐	☐	☐	☐
2. **Within the past ten years, has any proposed insured been diagnosed with or been treated for:**						
a. Alcohol or drug abuse, or disorder of the stomach, liver, intestines, or kidneys?	☐	☐	☐	☐	☐	☐
b. Cancer, tumor, diabetes, or disorder of the blood?	☐	☐	☐	☐	☐	☐
c. Asthma, lung disease, seizure, depression, or mental, psychiatric, or neurologic disorder?	☐	☐	☐	☐	☐	☐
d. Heart or circulatory disease or abnormality, chest pain, shortness of breath, murmur, stroke, or high blood pressure?	☐	☐	☐	☐	☐	☐
3. Is any proposed insured taking any prescribed medication at regular intervals? If "Yes", indicate name of medication in Details below.	☐	☐	☐	☐	☐	☐

4. What is the height, weight, and birth state of each proposed insured?

First Name	Hgt. Wgt.	Birth State

5. **Personal physician for each proposed insured** (if none, enter "None")

Proposed Insured	Physician	Address	City, State

6. **Details, including date, diagnosis, type of treatment, and current condition**

Ques No.	Proposed Insured	Details	Name, address and phone # of physician(s)

REPRESENTATIONS: I represent to the best of my knowledge and belief that all statements and answers in this application are complete, true and correctly recorded, and are made as a consideration for the insurance applied for. I understand that Texas Life Insurance Company will rely on my statements and answers as being true and complete in deciding whether to issue insurance on the proposed insured(s). Insurance is effective under the policy only when it is delivered to the owner and the full first premium is paid in cash. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X ______________________ Employee (and policyowner) Signature

X ______________________ Spouse Signature (or Child over 18) if to be insured

X ______________________ Enroller/Agent Signature

______________________ Print Enroller/Agent Name

Agt No. ________ Date ________ City ________ State ________

REPLACEMENT FORM

Georgia
Replacing Your Life Insurance
Two pages

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. You should ask the company or agent that sold your existing policy to give you information about it.

The following page contains a check list of some of the items you should consider in making your decision. **TAKE TIME TO READ IT**.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required by law to notify your existing company that you may be replacing its policy.

additional information regarding replacements

This section is designed to provide you with additional information regarding positive and negative aspects of replacements. Since we cannot provide you with all of the relevant information, we recommend that you contact your existing insurance company. You should consider that:

- If either the proposed policy or existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.
- If the policy coverages are similar, the premiums for the new policy may be higher because premium rates increase as your age increases. Additionally, if your health has changed, you may no longer be insurable.

Form: 411-GA-8/97

- The period of time during which your existing insurance company could contest the policy because of a material misstatement or omission on your part (called the contestability period) or deny coverage because of suicide may have expired or expire earlier than it will under the proposed policy.
- Your existing policy may have options or features that are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life.
- The cash value and dividends, if any, of the proposed policy may grow slower initially because the company will incur the cost of issuing your new policy.

There are positive aspects to replacements as well. For example, the proposed policy may provide a better match of insurance coverage with insurable needs, more insurance coverage for a lower cost, or a faster accumulation of cash value than with the existing policy.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

caution

If after studying the information made available to you, you decide to replace your existing life insurance, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.

information on policy being replaced

________________	________________	________________
Policy Number	Issuing Company	Insured's Name

Applicant Signature:________________________ Date:________________

Agent Signature:________________________ Date:________________

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