FAXABLE Multi-State Fully Underwritten Application

INSTRUCTIONS

PLEASE MAKE CERTAIN:

1. The attached Notice of Insurance Information Practices is delivered to the proposed insured before completion of the application.
2. **The Conditional Receipt is given to the premium payor whenever payment is collected. Applications for amounts of insurance that exceed $500,000 may be submitted; however, amounts over $500,000 will not be covered by the Conditional Receipt. Do not accept payment for an amount of insurance that exceeds $500,000, or if the proposed insured has been treated for heart disease, stroke, diabetes or cancer within the past 12 months, or if the case is subject to a flat extra because of a hazardous avocation (such as aviation).**
3. The proposed insured, spouse and applicant/owner, if any, sign the application form where indicated.
4. If the proposed insured is under 15 (18 in PA), the application is signed by a parent or guardian.
5. All sections of the application required for coverage are completed (please type or print in blue or black ink).
6. That proposed insured requesting monthly bank draft understands that he/she has the option of having the initial premium drafted directly from his/her account. Please indicate preference by marking in the appropriate box in the Authorization to My Bank section.
7. Requests for a special effective date or a specific draft date for monthly bank draft withdrawals are indicated in the Special Requests section of the application. **Please notify individuals applying for Universal Life that the effective date and the draft date must be the same.**
8. That if the beneficiary of the additional insured is other than the proposed insured this is noted in the Special Requests section.

NOTICE OF INSURANCE INFORMATION PRACTICES

—DETACH AND DELIVER TO PROPOSED INSURED BEFORE COMPLETION OF THE APPLICATION—

As part of our routine underwriting procedures, an investigative consumer report may be obtained that will provide applicable information concerning character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates. You have the right to be personally interviewed if we order an investigative consumer report. Please notify us if this is your wish. You are also entitled to receive a copy of the investigative consumer report whether or not an interview is conducted. Further information on the nature and scope of such a report, if one is made, will be made available to you upon written request. Such request should be sent to Great American Life Insurance Company®, Life Division at P.O. Box 5416, Cincinnati, Ohio 45201-5416.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, 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 sent to such a company, the Bureau, on request, will supply such company with the information in its file. On 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The telephone number is (617) 426-3660.

The Company may also release information in its file to other life insurance companies and their reinsurers to whom you may apply for life or health insurance or to whom a claim for benefits may be sent.

You have a right to access personal information we maintain in our files and to request correction, amendment or deletion of any information you believe to be incorrect. You may request a description of established procedures that will allow access to and correction of such personal information. If you wish to have a more detailed explanation of our information practices, including your rights of access to and correction of personal information, please contact Great American Life Insurance Company, Life Division, Underwriting department, P.O. Box 5416, Cincinnati, Ohio 45201-5416.

AGREEMENT

I/we, the Proposed Insured(s), represent the statements in Part I and Part II (if Part II is required by the Company) of this application are true and complete to the best of my/our knowledge and belief. It is agreed: (a) the only statements that are to be considered as the basis of the policy are those contained in the application or in any amendment to the application; (b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT bearing the same date as this application; (c) if there is no prepayment made with this application, the policy will not take effect until the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II (if Part II Medical is required by the Company) of this application, and until the policy is delivered to the proposed owner; and (d) no one except the President, a Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.

I/we acknowledge receipt of NOTICE OF INSURANCE INFORMATION PRACTICES attached hereto and hereby authorize preparation of an investigative consumer report.

Agents: Do not complete this Conditional Receipt or give it to an applicant unless the coverage applied for is standard, non-rated coverage without an exclusion or restrictive endorsement and at least the first full premium for the plan and mode is submitted (including pre-authorized order for withdrawl) with the application.

CONDITIONAL RECEIPT - Please Read Carefully

Unless each and every CONDITION stated in this receipt is fulfilled, no insurance coverage is provided until the policy is physically delivered. No agent or broker is authorized to change, alter or waive any of the conditions or provisions of this receipt.

MAKE CHECKS PAYABLE ONLY TO GREAT AMERICAN LIFE INSURANCE COMPANY

RECEIVED from ____________________________ $ ______________________________ by ☐check, ☐pre-authorized order for withdrawal, or ☐other, in connection with the attached application for life insurance.

The words "you" and "your" used below refer to the person or persons who are the Proposed Insured(s) on the attached application. The words "we", "our" and "us" used below refer to Great American Life Insurance Company.

CONDITIONS

You will have no coverage under this receipt unless **all** of the following conditions are fulfilled:

- You complete all required medical examinations, tests, and other screenings and we receive the results at our home office within 30 days from the date of the application.
- We determine that you are insurable for the exact policy and coverage amount you applied for at our standard premium rates without a substandard rating, exclusion, restrictive endorsement or any change in the premium rate. We make this determination according to our underwriting rules and standards.
- We receive the full initial premium for the mode of payment you selected. If you have applied for universal life insurance, the premium payment must be at least the minimum monthly premium.
- Your health and all factors affecting your insurability are as stated in the application.

EFFECTIVE PERIOD

The date any coverage under this receipt will begin is the date when the **last** of the following events occurs:

- You complete all parts of the application, including any supplement or addendum we may require.
- Any date you requested in the application that is acceptable to us.
- You complete the last required medical test, examination, or screening.
- We receive the full initial premium for the mode of payment chosen.
- We receive any required additional information at our home office.

The date any coverage in effect under this receipt will end is the date when the first of the following events occurs:

- The date your policy is delivered or you refuse to accept delivery.
- The date we return any premium paid.
- Sixty (60) days from the date of this receipt.

OTHER LIMITATIONS

- The maximum possible coverage under this receipt is the lesser of the amount of coverage applied for or $500,000, including all coverage in force or applied for with us.
- This receipt provides no insurance for riders or additional benefits.
- If you do not meet all conditions, or you die by suicide, our liability is limited to a refund of the premium paid.
- There will be no coverage if the sum received is paid by check or pre-authorized order for withdrawal that is uncollectible upon initial presentation.

X __________________________________ __________
Agent Name (please print) Date

X __________________________________ __________
Signature of Agent Agent No.

X __________________________________ __________
Signature of Proposed Insured Date

X __________________________________ __________
Signature of Spouse (if applicable)

X __________________________________ __________
Signature of Owner (if other than Proposed Insured)

GREAT AMERICAN LIFE INSURANCE COMPANY®

Life Division • P.O. Box 5416 • Cincinnati, Ohio 45201-5416

PART 1 Please Print

1. PROPOSED INSURED ______________________
First Middle Initial Last

Address ______________________

City ______________ State _____ Zip ________

Home Phone ____________ Bus. Phone ____________

Soc. Sec. No. ______________________

Complete only if Owner is not Proposed Insured

2. OWNER ______________________

Relationship ____________ Birth Date ____________

Address ______________________

City ______________ State _____ Zip ________

Soc. Sec./Tax I.D. No. ______________________

❒ Male ❒ Female Birth Date________ Age____ Driver's License No.________________ State Issued________

Birth State____________ Marital Status____________

Are you a U.S. Citizen? ❒ Yes ❒ No If not, do you hold a permanent VISA or Green Card? ❒ Yes ❒ No

Employer Name ______________________ Occupation ______________

Send Premium Notice To: ❒ Proposed Insured ❒ Owner ❒ Other (Give name/address in Special Requests)

3. INSURANCE APPLIED FOR: Plan Name______________________ Amount $____________

4. PREMIUM MODE: ❒ Annual ❒ Semiannual ❒ Quarterly ❒ Monthly Bank Draft ❒ Other (Specify)____________

Scheduled Premium (Modal-UL Only) $____________ Additional First Year Premium (UL Only) $____________

5. DEATH BENEFIT OPTION (UL Only) ❒ Option A ❒ Option B

6. ADDITIONAL BENEFITS BY RIDER ❒ Spouse/Additional Insured Term Insurance______________________
(Spouse/Additional Insured Driver's License No./State)

❒ Waiver of Scheduled Premium (UL) ❒ Waiver of Premium (Term) ❒ Accidental Death Benefit Amount____________
(Up to $200,000)

❒ Children's Term Insurance ❒ Other Riders______________________

7. Name of Other Insureds	Birth Date	Sex	Age	Height/ Weight	Birth State	Soc. Sec. No.	Relationship To Insured	Amount Applied For

8. BENEFICIARY OF THE PROPOSED INSURED (For Additional Insured, please list in Special Requests section.)

Primary ______________________ Soc. Sec. No. ____________ Relationship ____________
Name & Address

Contingent ______________________ Soc. Sec. No. ____________ Relationship ____________
Name & Address

9. LIFE INSURANCE (On any person proposed for coverage)

Will any life insurance or annuities for this or any other company be replaced, discontinued, reduced or changed if insurance now applied for is issued? ❒ Yes ❒ No

If "Yes," give details: ______________________
Insured Company Policy Number Amount Policy Date

____
Insured Company Policy Number Amount Policy Date

10. List all life insurance in force or currently applied for. (❒ Check here if "none.")

____
Company Amount Plan Year Issued Amount ADB Standard Rated

____
Company Amount Plan Year Issued Amount ADB Standard Rated

11. TOBACCO/NICOTINE HABITS

A. PROPOSED INSURED: Used any tobacco/nicotine last 5 years? ❒ Yes ❒ No Last 3 years? ❒ Yes ❒ No

Last 12 Months? ❒ Yes ❒ No Form of tobacco/nicotine? ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Other ____________

B. PROPOSED SPOUSE/ADDITIONAL INSURED: Used any tobacco/nicotine last 5 years? ❒ Yes ❒ No Last 3 years? ❒ Yes ❒ No

Last 12 Months? ❒ Yes ❒ No Form of tobacco/nicotine? ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Other ____________

12. HAS ANY PERSON PROPOSED FOR COVERAGE...

	Yes	No
a. Ever applied for insurance or reinstatement that was declined, postponed, rated, modified or had any such insurance cancelled or a renewal premium refused?	❐	❐
b. Ever received or claimed indemnity benefits or a payment for any injury, sickness or impaired condition?	❐	❐
c. Engaged in or plan to engage in any form of motorized racing, scuba diving, parachuting, hang-gliding, ballooning or mountain climbing? (If "Yes," complete avocation questionnaire.)	❐	❐
d. Ever made any flights as a pilot, student pilot, or crew member of any aircraft in the past three years or intend to do so in the future? (If "Yes," complete aviation questionnaire.)	❐	❐
e. Been charged with but not acquitted of the violation of any criminal law?	❐	❐
f. Had in the past five years any motor vehicle violations or had your license suspended or revoked?	❐	❐
g. Any intention of travelling or residing outside the U.S. or Canada in the next year?	❐	❐
h. Belong to or intend to join any active or reserve military or naval organization?	❐	❐
i. Ever filed for bankruptcy?	❐	❐

If answering "Yes" to any of the above, questions a. through i., please give details including name of person__________________

____

____

PART II

To the best of your knowledge and belief

	Proposed Insured		Spouse/Add'l Insured		All Children	
	Yes	No	Yes	No	Yes	No
1. Has anyone proposed for coverage ever been treated for or had:						
a. Impairment of the eyes or ears?	❐	❐	❐	❐	❐	❐
b. Dizziness, fainting, convulsions, headache, paralysis or stroke within the last 10 years?	❐	❐	❐	❐	❐	❐
c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema or chronic respiratory disorder within the last 10 years?	❐	❐	❐	❐	❐	❐
d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?	❐	❐	❐	❐	❐	❐
e. Jaundice, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver or gall bladder?	❐	❐	❐	❐	❐	❐
f. Sugar, proteinuria, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	❐	❐	❐	❐	❐	❐
g. Diabetes, thyroid or other endocrine disorders?	❐	❐	❐	❐	❐	❐
h. Disorder of the breasts or pelvic organs?	❐	❐	❐	❐	❐	❐
i. Neuritis, arthritis or disorder of the muscles or bones, including the spine, back or joints?	❐	❐	❐	❐	❐	❐
j. Disorder of skin, lymph glands, cyst, tumor or cancer?	❐	❐	❐	❐	❐	❐
k. Anemia or other disorder of the blood?	❐	❐	❐	❐	❐	❐
l. Alcoholism or addiction to habit-forming drugs?	❐	❐	❐	❐	❐	❐
m. Any mental or physical disorder not listed above?	❐	❐	❐	❐	❐	❐
2. Has anyone proposed for coverage:						
a. Had a physical checkup, consultation or surgery within the last five years?	❐	❐	❐	❐	❐	❐
b. Been a patient in a hospital, clinic or other medical facility within the last five years?	❐	❐	❐	❐	❐	❐
c. Had an electrocardiogram, X-ray or other diagnostic test within the last five years?	❐	❐	❐	❐	❐	❐
d. Been advised to have any diagnostic test, hospitalization or surgery, which was not completed?	❐	❐	❐	❐	❐	❐
e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?	❐	❐	❐	❐	❐	❐
f. Ever had any disorder of menstruation, pregnancy or other reproductive organs?	❐	❐	❐	❐	❐	❐
3. Are you now pregnant? (If "Yes," expected due date___ /___/___)	❐	❐	❐	❐	❐	❐
4. Is anyone proposed for coverage now under medical observation or treatment other than as stated above?	❐	❐	❐	❐	❐	❐

Please give details below if you answered "Yes" to any above questions.

Quest. No.	Name of Person	Details (Name of condition, date of onset, duration, current treatment and condition, etc.)	Complete Names, Addresses and Phone Numbers of Physicians and Hospitals

5. PROPOSED INSURED'S Height _______ ft. _______ in. Weight _______ lbs. Weight loss in past year _______ lbs.

6a. PERSONAL PHYSICIAN (❒ Check here if "none.") Name ______________________________

Address ______________________________ Phone ______________________________

b. Date and reason last consulted ______________________________

c. Treatment given or medication prescribed ______________________________

7a. PROPOSED INSURED'S FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/Sisters			

7b. SPOUSE/ADDITIONAL INSURED'S FAMILY HISTORY

	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Brothers/Sisters			

SPECIAL REQUESTS

AUTHORIZATION AND AGREEMENT

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company® or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children.

I/we understand the information obtained by use of the authorization will be used by Great American Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by Great American Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, or other persons or organizations, performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this authorization. I/we agree a photographic copy of this authorization shall be as valid as the original. I/we agree this authorization shall be valid for two and one-half years from the date shown below.

I/we, the Proposed Insured(s), represent the statements in Part I and Part II (if Part II is required by the Company) of this application are true and complete to the best of my/our knowledge and belief. It is agreed: (a) the only statements that are to be considered as the basis of the policy are those contained in the application or in any amendment to the application; **(b) any prepayment made with this application will be subject to the provisions of the CONDITIONAL RECEIPT bearing the same date as this application; (c) if there is no prepayment made with this application, the policy will not take effect until the first premium is paid during the lifetime of the proposed insured and while his/her health and the facts and other conditions affecting his/her insurability are as described in Part I and Part II (if Part II Medical is required by the Company) of this application, and until the policy is delivered to the proposed owner;** and (d) no one except the President, a Vice President or the Secretary can make, alter or discharge contracts or waive any of the Company's rights or requirements.

I/we acknowledge receipt of NOTICE OF INSURANCE INFORMATION PRACTICES attached hereto and hereby authorize preparation of an investigative consumer report.

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

Date ______________ City/State ______________

Witness **X** ______________________________
Name

____
Agent Name (Printed) Code %

____
Agent Name (Printed) Code %

____
General Agency Code

Agent Signature **X** ______________________________

Signature **X** ______________________________
Proposed Insured [Parent or Guardian if Proposed Insured is a juvenile under age 15 (18 in PA)]

Signature **X** ______________________________
Spouse/Additional Insured if insurance applied for

Signature **X** ______________________________
Applicant/Owner if other than Proposed Insured
(Give title if signed on behalf of business)

To the best of your knowledge, does the policy applied for involve replacement in whole or in part of any existing life insurance or annuity? ❒ Yes ❒ No

If "Yes," have you complied with the appropriate replacement requirements? ❒ Yes ❒ No

TAXPAYER IDENTIFICATION NUMBER (Required by IRS Code Section 3406 if policyowner is a corporation or business.)

Enter Taxpayer Identification Number and sign below ____|____|____ ____|____

Social Security Number Employer Identification Number

❒ Check if you are subject to backup withholding under the provisions of Section 3406(a)(1)(c) of the Internal Revenue Code.

Certification–Under penalties of perjury, I certify that: (1) the number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me); and (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions– You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Date ______________________ Signature **X** ______________________

Applicant/Owner (Give title if signed on behalf of business)

IF MONTHLY BANK DRAFT, ATTACH VOIDED CHECK HERE AND SIGN AUTHORIZATION.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits made to my account and drawn by Great American Life Insurance Company®, Cincinnati, Ohio, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to such debit shall be the same as if it were a check drawn on you and signed personally by me. I hereby agree that if any debit is not paid by you for any reason, with or without cause or whether such nonpayment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such nonpayment results in the forfeiture of insurance. This authorization is to remain in full force and effect until revoked by me upon 30 days written notice, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit to my account.

Date ______________________ Signature **X** ______________________

(As it appears on bank records)

INITIAL PREMIUM

❒ I authorize Great American Life® to draft any/all initial premium due from my account at which time my policy is issued and activated.

❒ I DO NOT authorize Great American Life to draft any/all initial premium due from my account. I understand a separate check/money order will be requested.

Date ______________________ Signature **X** ______________________

(As it appears on bank records)

AGENT'S STATEMENT

1. Which Underwriting Class was quoted?

Proposed Insured	Spouse/Additional Insured
❒ Super Preferred	❒ Super Preferred
❒ Preferred Plus	❒ Preferred Plus
❒ Preferred	❒ Preferred
❒ Select Plus	❒ Select Plus
❒ Select	❒ Select
❒ Standard	❒ Standard
❒ Other ____________	❒ Other ____________

2. Was the client seen at the time of application? ❒ Yes ❒ No

3. Has any premium been given in connection with this application?
❒ Yes ❒ No
If "Yes," state amount paid for which conditional receipt has been given the terms of which are hereby agreed to: $ ____________

FINANCIAL INFORMATION OF PROPOSED INSURED

1. Gross annual income of proposed insured........... $ ____________
2. Personal net worth... $ ____________
3. Purpose of insurance: ______________________

Complete this section if insurance is business coverage:

1. Net worth of business: (last 2 years) $______/ $______

2. Gross annual sales: (last 2 years) $______/ $______

3. Percentage of business owned by proposed insured ______%

4. Are other partners/owners/executives being insured by the business?
❒ Yes ❒ No
If "Yes," for how much? ____________
If "No," please explain: ____________
____

5. Business is a: ❒ C Corporation ❒ S Corporation ❒ Partnership ❒ Sole Proprietorship

6. Proposed Insured is: ❒ Majority Owner ❒ Officer ❒ Minority Owner ❒ Partner ❒ Key Executive

7. Purpose of insurance: ❒ Buy/Sell ❒ Key Person ❒ Split Dollar ❒ Deferred Compensation