PART I
Use black ink only.
All Persons Applying For Coverage:

Application made to:

ERIE FAMILY LIFE INSURANCE COMPANY

Erie, PA 16530

☐ All Applicants
☐ Adult
☐ Juvenile (Ages 0-14)

FULL NAME	SEX	RELATIONSHIP TO PROPOSED INSURED	DATE OF BIRTH	STATE OF BIRTH	HGT.	WGT.	NAME, ADDRESS & PHONE NO. OF PERSONAL PHYSICIAN (Include date last seen and reason)
		PROPOSED INSURED					
		SPOUSE					

1. Address .... Number .... Street
   .... City .... State .... Zip Code -
   Phone Number ( ) .... - ....
2. How long at this address? .... Previous address last 2 years ....
3. Employer's Name & Address ....
4. Occupation .... How long? ....
   (Describe Duties) ....
5. Send Premium Notice to: ☐ Home ☐ Business
6. Proposed Insured is: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
7. Social Security Number ....
8. Will this policy replace insurance or annuities with any company? ☐ Yes ☐ No (If "Yes," complete appropriate replacement forms in duplicate and mail one copy to EFL.)
9. Are you currently applying for or do you have any other life insurance in force other than this application?
   ☐ Yes ☐ No (If "Yes," list below)

Company	Amount	Year Issued

10. Policy Applied For — Amount — No. of Yrs.
    Base plan ....
    ☐ Waiver of Premium (Ages 15-55)
    ☐ Accidental Death (Ages 5-60) $ ....
    ☐ GIO (Ages 0-37) $ ....
    ☐ Children's Term Ins. Rider .... Units
    ☐ Spouse-Children Term Ins. Rider .... Units
    ☐ Payor (Ages 0-14) See questions 21—25.
    ☐ Automatic Premium Loan Provision

PAYMENT PLAN
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly
☐ Chek-matic (Attach Authorization) ☐ Other ....

11.

Primary Beneficiary	Relationship	Birthdate
		__/__/__
Contingent Beneficiary	**Relationship**	**Birthdate**
		__/__/__

12. Special Requests

(If corporation is to be policyowner, please indicate here and have Corporate Officer sign on page 2 at bottom right with their title.)

Has any person proposed for insurance: — Yes No

13. Ever received disability benefits or been declined for insurance or offered a policy with an extra premium charge? ☐ ☐
14. Flown as pilot or crew member within past 3 years or have any intentions of doing so in future? (If "Yes," complete Aviation Questionnaire.) ☐ ☐
15. Had their driver's license revoked or suspended or had any driving while intoxicated violations within the past 3 years? ☐ ☐
    If "Yes," give license # .
16. Participated in auto racing, motorcycle racing, sky diving, or scuba diving within the past 3 years? (If "Yes," complete the appropriate questionnaire.) ☐ ☐
17. Traveled outside of the United States or Canada in past 3 years or have any intentions of doing so in next 3 years? ☐ ☐
18. Used tobacco in any form or any other nicotine dispensing products in the past 12 months? ☐ ☐
19. Been convicted of a felony within the past 10 years? ☐ ☐

DETAILS: (Questions 13-19) ....

JUVENILES PROPOSED FOR COVERAGE (Ages 0-14) — Yes No

20. a. Is every child proposed for coverage in sound health? ☐ ☐
    b. Does any child have abnormal hearing or sight? ☐ ☐
    c. Does any child have a mental or physical defect or deformity? ☐ ☐
    d. Has any child had medical advice or treatment in past 5 years? ☐ ☐
    e. Has any child been declined for insurance or offered a policy with an extra premium charge? ☐ ☐

DETAILS: Nature of Ailment And Treatment	Dates From/To	Name & Address of Physician

PLEASE NOTE	**Unless requested in Item 12, a minor proposed Insured will assume policy ownership at age 18.**

PAYOR BENEFIT SECTION
(If Payor Benefit is desired, complete questions 13-19, 21-25 & 26-34 for Adult Payor)

21. Name of Payor ....
22. Relationship to Proposed Insured ....
23. Date of Birth .... State of Birth ....
24. Occupation (Describe Duties) ....
25. Payor Height .... Weight ....

PART II (Complete this section for all applicants age 15 or over. Also complete if Payor Benefit is desired.)

	YES	NO
26. In the past 5 years, has any person proposed for insurance ever used:		
a. barbiturates, sedatives or tranquilizers without a medical prescription?	☐	☐
b. L.S.D., marijuana, cocaine or other narcotic drugs?	☐	☐
27. Has any person proposed for insurance ever received medical treatment for alcoholism or narcotic drug abuse?	☐	☐
28. Does any person proposed for insurance have a family history of heart disease, diabetes or mental illness?	☐	☐
29. Has any person proposed for insurance ever had or been told they had:		
a. fainting spells, stroke, epilepsy, mental illness or any disease or disorder of the brain or nervous system?	☐	☐
b. any disease or disorder of the lungs, stomach, intestines, liver, kidneys, glands or blood?	☐	☐
c. high blood pressure, chest pain, rheumatic fever, heart murmur or any disease or disorder of the heart or circulatory system?	☐	☐
d. diabetes or sugar, albumin or blood in the urine?	☐	☐
e. any disease or disorder of the back, bones, joints or muscles?	☐	☐
f. cancer, tumor, ulcer or venereal disease?	☐	☐
g. any impairments of hearing or sight?	☐	☐
30. Has any person proposed for insurance received treatment for or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a member of the medical profession or tested positive for antibodies to the AIDS virus?	☐	☐
31. Is any person proposed for insurance now pregnant? (Expected Delivery Date ______________________)	☐	☐
32. Does any person proposed for insurance now have any disease or disorder or are they receiving treatment or taking medication?	☐	☐
33. Has any person proposed for insurance lost 15 lbs. or more in the past year?	☐	☐
34. Has any person proposed for insurance been hospitalized or had medical treatment or EKG or other diagnostic testing in the last 5 years or do they anticipate surgery in the next 6 months?	☐	☐

DETAILS: (Questions 26-34)

NAME OF PERSON	IMPAIRMENT	NUMBER OF OCCURRENCES	DATES: FROM—TO	COMPLETE RECOVERY?	NAME, ADDRESS AND PHONE NO. OF PHYSICIAN

I declare that I have read and understood all the statements shown above and on the front of the application, that they are true and complete to the best of my knowledge and correctly recorded.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc. or other organization, institution or person, that has any records or knowledge of any person proposed for insurance, to give to the Erie Family Life Insurance Company or its reinsurers, any such information. I hereby acknowledge receipt of the Notice Regarding The Medical Information Bureau, Inc. and the Notice Regarding The Fair Credit Reporting Act. (A photographic copy of this authorization shall be as valid as the original.) **I agree that no insurance shall be effective until a policy is issued and delivered and the first premium paid all within the lifetime and good health of the proposed insured.**

Signed at .... Date ....
City State

X .... Signature of Proposed Insured—if age 18 or over

X .... Signature of Owner—if other than Proposed Insured or if Proposed Insured is a minor

X .... Signature of Agent Agent's Number

X .... Signature of Spouse if covered, or Parent if Proposed Insured is a minor

AGENT'S REPORT:

.... Agency Name

( ) - .... Agent's Phone Number

.... Agent Number

1. How long and how well have you known proposed insureds? .... Years ☐ Well ☐ Slightly ☐ Not Known ☐ Relative
2. To the best of your knowledge and/or understanding, will this policy, if issued, replace any existing coverage? ☐ Yes ☐ No
3. If you are aware of anything that suggests the Proposed Insureds may not be qualified for this policy, please attach an explanation.
4. Are you arranging for a medical examination? ☐ Yes ☐ No If "Yes," is the exam with a: ☐ Paramedic ☐ Physician
5. Are you arranging for additional testing? ☐ Yes ☐ No

   If "Yes," please indicate any of the following: ☐ EKG ☐ Blood Profile ☐ HIV (AIDS) ☐ Antibody ☐ Timed Vital Capacity (TVC) (Consult Agent's Life Manual for testing requirements.) All blood drawing must be done by a qualified paramed.

PREMIUM CALCULATION

—Attach Securely to Application—

	PREMIUM PER $1,000	NO. OF $1000's	TOTAL
Basic Policy*			$
Policy Fee	—	—	$
Rider Premiums			$
			$
*Including WP/ADB if desired		TOTAL PREMIUM	$

CASH WITH APPLICATION $

☐ Full Premium

☐ Partial Premium

ATTENTION AGENT: PLEASE COMPLETE IF APPLYING FOR OVER $50,000.

PLEASE INDICATE PURPOSE OF INSURANCE, EITHER (A) PERSONAL OR (B) BUSINESS.

(A) PERSONAL INSURANCE: ☐ Income Replacement ☐ Personal Creditor

☐ Other ____________________________

IF APPLYING FOR $100,000 OR MORE, INDICATE:

Estimated Annual Net Earned Income $__________________________

Estimated Annual Net Unearned Income $__________________________

(B) BUSINESS INSURANCE: ☐ Key Person ☐ Stock Purchase ☐ Partnership Buy/Sell ☐ Business Creditor

☐ Other ____

Estimated Annual Net Earned Income of Applicant $ ________________

Estimated Annual Net Income of Business $__________________

Estimated Net Worth of Business $__________________

CONDITIONAL RECEIPT

DO NOT DETACH UNLESS FULL FIRST PREMIUM IS PAID WITH APPLICATION

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY APPLIED FOR UNLESS AND UNTIL **ALL** CONDITIONS, INCLUDING THOSE FOUND ON THE REVERSE SIDE OF THIS RECEIPT, ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

IF, WITHIN THE LAST 12 MONTHS, ANY PERSON PROPOSED FOR COVERAGE HAS BEEN TREATED FOR OR HAD ANY HEART TROUBLE, STROKE, DIABETES, MENTAL ILLNESS, CANCER, OR ABNORMAL BLOOD PRESSURE REQUIRING MEDICATION, NO PAYMENT MAY BE ACCEPTED WITH THE APPLICATION.

Received $ _____________________________________ from _____________________________________ on ___________________________________

in connection with an application for life insurance bearing the same date as this receipt.

Date ___________________ Agent ____

IF,
(1) an amount equal to the first full premium is submitted; **and**
(2) all underwriting requirements, including any medical examinations required by the company's rules, are completed; **and**
(3) the proposed insureds are, on the effective date indicated below, risks insurable for insurance exactly as applied for, without modification of plan, premium rate or amount, according to the company's rules and practices,

THEN insurance under the terms of the policy applied for—in the same manner and subject to the same rights, conditions, and defenses as if the policy applied for had been issued and delivered—shall become effective on the latest of (a) the date of the application, (b) the date of completion of all underwriting requirements, and (c) any date of issue requested in the application.

IF ALL OF THE CONDITIONS OF THIS RECEIPT HAVE BEEN MET, THEN THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY APPLIED FOR SHALL NOT EXCEED $100,000.

If any of the above conditions is not met, the liability of the company shall be limited to the return of the amount submitted.