JEFFERSON NATIONAL®

Please fax or send completed application (along with this cover sheet) to:

FAX:
1-608-755-7955

MAIL:
SAS

Simple Term
PO Box 1086

Janesville, WI 53547

Date

Name

phone number

email address

Agent ID#

To learn more please visit our websites at www.jeffersoninsurance.com or www.sas-it.com.
Jefferson National is domiciled in Dallas, TX, with offices in New York, NY in and Louisville, KY.
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JEFFERSON NATIONAL®

Application for Life Insurance

JEFFERSON NATIONAL LIFE INSURANCE COMPANY
Administrative Office: 9920 Corporate Campus Dr, Suite #1000,
Louisville, KY 40223
Home Office: Dallas, TX 75201

1. Insured Information		Owner Information	
Name		Name	
Street Address		Street Address	
City State Zip		City State Zip	
e-mail	Phone	e-mail	Phone
Sex M ☐ F☐ / Date of Birth	Place of Birth	Sex M ☐ F☐ / Date of Birth	Place of Birth
Social Security Number	Driver's License # & State	Social Security Number	
Height feet inches	Weight lbs.		

2. Primary Beneficiary		Contingent Beneficiary	
Name	Relationship	Name	Relationship

3. Plan Applied For	☐ Ten Years ☐ Fifteen Years ☐ Twenty Years ☐ Thirty Years
4. Coverage Amount	$
5. Payment Frequency	☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

6. Payment Method	
☐ Charge My Credit Card	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Card Number Exp.
☐ Debit My Checking Account	Bank Name Account Number ABA Number (first 9 numbers in the lower left-hand corner of your check – you may also attach a voided check)
7. Replacement	Do you plan to replace, change or modify any existing life insurance as a result of this application? ☐ Yes ☐ No (if yes, additional forms may be required, depending upon state requirements)

8. Underwriting	
1. In the past 12 months have you smoked cigarettes, cigars, pipes or used tobacco or nicotine in any form including snuff, dip, chew, nicotine patch, gum or other substitutes?	Y ☐ N ☐
2. In the past 5 years, have you had or been treated for or consulted a physician or other practitioner for any of the following: heart or coronary artery disease or disorder, stroke, peripheral vascular disease, cancer, diabetes, hepatitis C, cirrhosis, pancreas disease or disorder, emphysema or chronic lung or pulmonary disease (COLD or COPD), alcohol or drug use?	Y ☐ N ☐
3. In the past 5 years, have you been hospitalized for the following: chest pain, high blood pressure, asthma, depression, manic-depression, other mental and nervous disorder, paralysis, seizure, anemia, or kidney or liver disease or disorder (excluding kidney stones)?	Y ☐ N ☐
4. In the past 2 years, have you had your driver's license revoked, suspended or been convicted of reckless driving, driving without a valid license or for driving while under the influence of alcohol or drugs (DWI, DUI)? Or have you had more than 2 moving violations in the past 12 months?	Y ☐ N ☐
5. In the past or next 12 months, have you engaged in or do you plan to engage in risky activities, extreme sports or have you flown a plane other than as a commercial airline pilot? Or are you engaged in a hazardous occupation that exposes you to the risk of loss of life?	Y ☐ N ☐
6. Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system or have you had a positive HIV test?	Y ☐ N ☐
7. In the past 12 months, have you either been hospitalized for 5 or more consecutive days, or missed 5 or more consecutive days from work or school other than for vacation or family leave?	Y ☐ N ☐

9. Fraud Warnings

Notice to residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial for insurance benefits.

10. Authorization & Signing

For underwriting and claims investigation purposes, I hereby authorize:

Any physician or other medical practitioner; hospital; clinic; pharmacist or other pharmacy benefit manager; insurance company consumer reporting agency; or the Medical Information Bureau (MIB) to give Jefferson National Life Insurance Company or its reinsurer(s) ALL MEDICAL INFORMATION on my behalf including findings on medical care, prescription histories, alcohol or drug abuse information, psychiatric or psychological care or examination (excluding psycho-therapy notes), or surgery, as they apply to me, my spouse, or any of my children who are to be insured.

I authorize Jefferson National Life Insurance Company or its reinsurer(s) to:

(1) Release any medical information to the MIB, Inc;
(2) Obtain an investigative consumer report on me. I know that I am entitled to a copy of this consumer report, upon request; I understand that I may request to be interviewed in connection with the preparation of the investigative consumer report and further understand that I am entitled to a copy of this consumer report, upon request;
(3) Obtain personal history information on me;
(4) Obtain medical history and prescription history information from my attending physician, clinic or hospital; pharmacists or other pharmacy benefit managers;
(5) Obtain motor vehicle records on me, my spouse or any of my children who are to be insured; and
(6) Obtain a credit or fraud report on me, my spouse or any of my children who are to be insured.

I understand that if I refuse to sign this authorization, Jefferson National Life Insurance Company will not be able to process my application. I understand that I may revoke this authorization by notifying Jefferson National Life Insurance Company in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by Jefferson National Life Insurance Company in reliance on this authorization and may result in this application or a claim being denied. **I understand** that a copy of this authorization will be included in my policy.I understand that the information described herein and disclosed to Jefferson National Life Insurance Company is protected by certain federal privacy regulations. Once Jefferson National discloses this information, as allowed in this Authorization, the information may no longer be subject to federal privacy regulations. **I understand**, however, that Jefferson National requires the entities listed above with whom it shares this information to enter into confidentiality agreements prohibiting the redisclosure of this information except as allowed herein.I understand that the coverage shall be in effect as of the date of this application if and only if the proposed insured is an insurable risk on the date of this application and the first scheduled premium is paid with this application.

By signing your name and date below, you agree: (1) that you have read and fully understand all the questions, answers and statements given in this application; (2) that the statements and answers on this application are full, complete and true to the best of your knowledge; (3) you intend to form a legally binding contract; (4) this authorization is valid for two and one-half years from this application date, except for claims investigation purposes. The authorization for the purpose of collecting information in connection with a claim for benefits is valid only for the duration of the claim; and (5) a printout of the terms stated above will constitute a "writing" under any applicable law or regulation. (6) you or your authorized representative are entitled to receive a copy of this application authorization form.

Insured's Signature ______________________ Date ________

Owner's Signature (if different from Insured) ______________________ Date ________

Company Representative Replacement Questionnaire

To the best of your knowledge, will this insurance that is applied for replace or change any existing life insurance or annuity? (if yes, please complete additional forms as required) Y ☐ N ☐

Authorized Company Representative Signature ______________________ Date ________