PRIMERICA®

Primerica Life Insurance Company
1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725
primerica.com

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE

Check One: | New Business Spouse Conversion Child Conversion Old Policy No. _____

PROPOSED INSURED INFORMATION

Personal Information

First Name _____ Last Name _____ M.I._____

Sex
Female
Male

Date of Birth _____
☐ Save Age Requested
SSN _All SSN numbers to be collected Later

Are you married?
Yes
No

Contact Information

Street Address _____

City _____ State _____ ZIP Code _____

Mobile Phone _____ Other Phone _____

Email _____

Driving and Employment Information

Do you have a driver's license? Yes No

Driver's License # _____ State _____

Are you employed? Yes No

Employer Name _____ Occupation _____

Years/Months Employed _____/_____

Total Monthly Earnings
If married, include household income $_____ If military, pay grade _____

Have you lived in the U.S. for the past 24 months? Yes No

If no, please indicate how long you have lived in the U.S.: Years/Months _____/_____

COVERAGE AND RIDERS

Which policy would you like? PowerTerm PrecisionTerm

Which premium class, plan and face amount would you like?

Premium Class	Plan	Face Amount
1	10 year	$_____
2	15 year	$_____
3		
4	20 year	$_____
5	25 year	$_____
6		
7	30 year	$_____
8	35 year	$_____
9		
10	Total Face Amount	$_____

Longest year plan will be the base plan.

Which additional riders would you like?

Child Rider (Maximum of $50,000) Amount $_____

Waiver of Premium

Would you like to maximize benefit with AIR?

Automatic Increase Request (AIR) Yes No

Which Premium Payment Option would you like?

Monthly Bank Draft (twelve times a year) Draft Day _____

Quarterly (four times a year)

Semi-Annually (twice a year)

Annually (once a year)

How much premium are you submitting with this Application? $0.00

POLICY OWNER

Policy Owner Information

Are you, the insured, also the policy owner? Yes No

If no, who is the policy owner?

__ Spouse __ Child/Grandchild __ Parent/Grandparent

Company/Employer/Business Partner Other Entity _____

Name of authorized signer
(If policy owner is a Company/
Employer/Business Partner/Other Entity) _____

Policy Owner Contact Information (if different from the insured)

Policy Owner Last Name or Entity Name _____ First Name _____

Date of Birth _____

Street Address _____

City _____ State _____ ZIP Code _____

SSN or TIN _____ Email _____

Mobile Phone _____ Other Phone _____

PAYOR

Payor Information

Is the policy owner also paying for the policy? Yes No

If no, who is paying for the policy?

Insured Child/Grandchild Parent/Grandparent

Insured's Spouse Company/Employer/Business Partner

Other Entity _____

Payor Contact Information (if different from the insured or policy owner)

Payor Name _____

Email _____ Mobile Phone _____

WHO ARE YOUR BENEFICIARIES?

Beneficiaries

First Name ______________________ Last Name ______________________ M.I. ______

Street Address ______________________

City ______________________ State ____________ ZIP Code ______________

Phone ______________________ SSN ______________________

Date of Birth ______________ Relationship to the Insured ______________ % (total must equal 100) __________

First Name ______________________ Last Name ______________________ M.I. ______

Street Address ______________________

City ______________________ State ____________ ZIP Code ______________

Phone ______________________ SSN ______________________

Date of Birth ______________ Relationship to the Insured ______________ % (total must equal 100) __________

First Name ______________________ Last Name ______________________ M.I. ______

Street Address ______________________

City ______________________ State ____________ ZIP Code ______________

Phone ______________________ SSN ______________________

Date of Birth ______________ Relationship to the Insured ______________ % (total must equal 100) __________

First Name ______________________ Last Name ______________________ M.I. ______

Street Address ______________________

City ______________________ State ____________ ZIP Code ______________

Phone ______________________ SSN ______________________

Date of Birth ______________ Relationship to the Insured ______________ % (total must equal 100) __________

- If you have additional beneficiaries, please attach a separate sheet providing the information requested above.
- All beneficiaries will receive the same amount, unless you tell us differently.
- If a beneficiary is a minor, financial guardianship will be required before the benefit can be paid.
- If a group is named as a beneficiary, each individual member must be named.
- All these beneficiaries may be changed by the policy owner. If you want any of these beneficiaries to be irrevocable, submit an Irrevocable Beneficiary Request.

WHO ARE YOUR BENEFICIARIES?

Beneficiaries (continued)

First Name _____ Last Name _____ M.I._____

Street Address _____

City _____ State _____ ZIP Code _____

Phone _____ SSN _____

Date of Birth _____ Relationship to the Insured _____ % (total must equal 100) _____

First Name _____ Last Name _____ M.I._____

Street Address _____

City _____ State _____ ZIP Code _____

Phone _____ SSN _____

Date of Birth _____ Relationship to the Insured _____ % (total must equal 100) _____

Contingent Beneficiaries (Will only receive a death benefit if all Beneficiaries die before the Insured)

First Name _____ Last Name _____ M.I._____

Street Address _____

City _____ State _____ ZIP Code _____

Phone _____ SSN _____

Date of Birth _____ Relationship to the Insured _____ % (total must equal 100) _____

First Name _____ Last Name _____ M.I._____

Street Address _____

City _____ State _____ ZIP Code _____

Phone _____ SSN _____

Date of Birth _____ Relationship to the Insured _____ % (total must equal 100) _____

- If you have additional beneficiaries, please attach a separate sheet providing the information requested above.
- All beneficiaries will receive the same amount, unless you tell us differently.
- If a beneficiary is a minor, financial guardianship will be required before the benefit can be paid.
- If a group is named as a beneficiary, each individual member must be named.
- All these beneficiaries may be changed by the policy owner. If you want any of these beneficiaries to be irrevocable, submit an Irrevocable Beneficiary Request.

TELL US ABOUT YOUR EXISTING INSURANCE

Do you have any existing life insurance or annuities in force?	Yes	No
Will you replace any existing insurance or annuities including discontinuing making premium payments, surrendering, forfeiting, assigning, or otherwise terminating an existing policy or annuity contract?	Yes	No

List below details of all Life Insurance or Annuities in force, including Group (GRP) and Individual (IND), on the insured and children (if children are applying for coverage) and whether the Insurance or Annuities will be replaced or changed. If additional space is needed, please attach a separate sheet.

Existing Insurance Company Full Name & Address (City, State, ZIP)	Name of Person(s) Covered	Policy or Certificate # of Existing Coverage	Face Amount	Date Issued	Replaced? GRP or IND?
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND
					Yes No GRP IND

TELL US ABOUT YOUR PERSONAL AND MEDICAL HISTORY

How tall are you? _____ft. _____in.	How much do you weigh? _____ lbs.

Section 1 (Check all that apply)

How often do you use tobacco or nicotine products, including cigarettes, cigars, chewing tobacco, snuff, e-cigarettes, vaping products, hookahs, pipes, nicotine patches, nicotine gums, smoking cessation medications or any other tobacco or nicotine product?

- Daily
- Weekly
- Monthly
- Occasionally, 12 or less times in the last 12 months (If checked, please provide type of tobacco or nicotine below)
  - Cigars, chewing tobacco, snuff, or pipes
  - Other tobacco or nicotine products
- I no longer use tobacco or nicotine products (If checked, please provide time of last use below, check only one)
  - Over 5 years
  - 3-5 years
  - 2-3 years
  - 1-2 years
  - Within 1 year
- I have never used tobacco or nicotine products

How often do you use marijuana or THC products (excluding CBD)? (Check only one)

- Over 4 times per week
- 3-4 times per week
- 1-2 times per week
- I use it occasionally (less than 1 time per week)
- I used it in the past but not in the last 12 months
- I have never used marijuana or THC products

Section 2 (Check all that apply)

In the past 10 years, have you been treated for or diagnosed by a member of the medical profession with:

- High blood pressure (hypertension)
- Diabetes
- Psychiatric, mental health, behavioral disorder or suicide attempt
- Cancer, leukemia, lymphoma (including Hodgkin's or Non-Hodgkin's), tumor or cyst, nodule, polyp, mass, lump or lesion
- Heart disease or disorder, stroke, transient ischemic attack (TIA), circulatory, blood, or thyroid disease or disorder
- Liver (including hepatitis), kidney, pancreas (other than diabetes), or other gastrointestinal (including stomach and intestines), urinary or reproductive disease or disorder
- Respiratory disease or disorder including chronic obstructive pulmonary disease (COPD), sleep apnea and asthma
- Seizure or epilepsy, brain, or nervous system disease or disorder
- Chronic pain, rheumatoid arthritis, systemic lupus or other disease or disorder of the bones, muscles, joints, connective tissue or immune system except those related to Human Immunodeficiency Virus (HIV or AIDS virus)
- In the past 5 years, except for Human Immunodeficiency Virus (HIV or AIDS virus), have you been treated for or been diagnosed by a member of the medical profession with any disease or disorder not listed above?
- None of the above for section 2

Section 3 (Check all that apply)

In the past 10 years have you:

- Tested positive for exposure to the HIV Infection or been diagnosed as having ARC or AIDs caused by the HIV infection or other sickness or condition derived from such infection?
- Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
- Pled guilty to or been convicted of a felony or do you have a felony charge currently pending against you?
- Other than marijuana, used opioids or narcotics, cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other habit-forming drug or controlled substance, except as prescribed by a physician?
- None of the above for section 3

Section 4 (Check all that apply)

In the past 3 years, have you:

- Had your driver's license suspended, revoked, or have you plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug, or have you pled guilty to or been convicted of 2 or more moving violations?
- Flown as a pilot, student pilot, or crew member on any aircraft (other than commercial airline) or intend to do so in the next 2 years?
- Engaged in any hazardous or extreme sport activities: SCUBA diving (excluding snorkeling), motor sports racing (air, water, ice, or land vehicles), mountain or rock climbing with specialized equipment or free solo climbing (excluding hiking, trekking or indoor rock climbing), airborne activities (aircraft record attempts, ballooning, BASE jumping, wing-suit diving, hang-gliding, powered hang-gliding, paragliding, home-built aircrafts, parachuting, skydiving, sky surfing, highlining, tricklining, gliding, ultralights or microlighting), or intend to do so in the next 2 years?
- None of the above for section 4

Section 5 (Check all that apply)

In the past 12 months, have you:

- Been hospitalized overnight (inpatient) other than for reasons disclosed in this application?
- Been medically advised to have any medical procedure (including surgery), hospitalization, treatment or test that was not completed or completed with results that you have not received?
- None of the above for section 5

Section 6 (Check all that apply)

- Do you have plans within the next 2 years to reside outside the United States or Canada for 30 days or longer?
- Has one or both of your biological parents died prior to age 65 due to cancer or cardiovascular disorder?
- Are you currently disabled or have you received disability benefits for a period of 6 months or longer (except for partial military disability or maternity) in the last 5 years?
- Have you had an application for life insurance declined by Primerica or another life insurance company in the last 5 years?
- None of the above for section 6

Section 7

Tell us about the medical professional(s) you see:

Do you have a primary care doctor, specialist, or healthcare facility that can provide the most complete and up-to-date information concerning your health? Yes No

If Yes, provide name, specialty, address, and phone number for all doctors or facilities you are seeing below:

	Doctor's or Facility's Name	Primary Care or Specialty (Ex. Cardiologist, etc.)	Address	Phone
1				
2				
3				
4				
5				
6				
7				

TELL US ABOUT ANY CHILDREN APPLYING FOR INSURANCE

If more than ten children are applying for insurance, please attach a separate sheet providing the information requested on this page.

Full Names of Each Child Applying for Insurance First M.I. Last	Resides with Insured Yes/No	Sex M/F	Relationship to Insured	Date of Birth (Not available after age 17)	Height ft. in.	Weight lbs.	SSN
1.							
2.							
3.							
4.							
5.							

Child

1 2 3 4 5 Has (or does) any child (Answer for each child by checking same number next to child's name above):

- Been treated for or diagnosed by a member of the medical profession with: premature birth, heart murmur, other heart disorder, cancer, leukemia, epilepsy, hepatitis, diabetes, kidney disorder or any congenital abnormality, hereditary, mental or developmental disorders?
- Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
- Tested positive for exposure to the HIV Infection or been diagnosed as having ARC or AIDs caused by the HIV infection or other sickness or condition derived from such infection?
- Been hospitalized for more than 5 days in the last 12 months for any condition other than already disclosed?
- Currently reside in another country?
- None of the above

The following additional questions must only be answered for any child over the age of 14.

Child

1 2 3 4 5 Has (or does) any child (Answer for each child by checking same number next to child's name above):

- Ever pled guilty to or been convicted of a felony or have a felony charge currently pending?
- Used illegal or illegally obtained drugs, including prescription drugs?
- Had 1 or more DUI/DWI conviction(s), or had a learner's permit or driver's license suspended or revoked?
- None of the above

TELL US ABOUT ANY CHILDREN APPLYING FOR INSURANCE (continued)

If more than ten children are applying for insurance, please attach a separate sheet providing the information requested on this page.

Full Names of Each Child Applying for Insurance First M.I. Last	Resides with Insured Yes/No	Sex M/F	Relationship to Insured	Date of Birth (Not available after age 17)	Height ft. in.	Weight lbs.	SSN
6.							
7.							
8.							
9.							
10.							

Child

6 7 8 9 10 Has (or does) any child (Answer for each child by checking same number next to child's name above):

Been treated for or diagnosed by a member of the medical profession with: premature birth, heart murmur, other heart disorder, cancer, leukemia, epilepsy, hepatitis, diabetes, kidney disorder or any congenital abnormality, hereditary, mental or developmental disorders?

Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?

Tested positive for exposure to the HIV Infection or been diagnosed as having ARC or AIDs caused by the HIV infection or other sickness or condition derived from such infection?

Been hospitalized for more than 5 days in the last 12 months for any condition other than already disclosed?

__ Currently reside in another country?

None of the above

The following additional questions must only be answered for any child over the age of 14.

Child

6 7 8 9 10 Has (or does) any child (Answer for each child by checking same number next to child's name above):

Ever pled guilty to or been convicted of a felony or have a felony charge currently pending?

Used illegal or illegally obtained drugs, including prescription drugs?

Had 1 or more DUI/DWI conviction(s), or had a learner's permit or driver's license suspended or revoked?

None of the above

APPLICATION AGREEMENT

This document contains what you agree to when you sign this Application. It describes the legal aspects of the application, and it also presents some of the benefits of the policy you're applying for. Finally, it gives you options for how to pay for a policy.

In this document, "you" and "your" mean the proposed policy owner, proposed insured person, or a third-party payor. "We" and "us" mean Primerica Life Insurance Company.

What do you agree to when you sign this Application?

By signing this Application, you agree to all of the following:

- You have applied for the insurance policy you want. Primerica offers two term life insurance policy series that provide the same death benefit at certain ages and face amounts. Neither has cash value.
    - The PowerTerm series offers insurance through a streamlined underwriting process that typically does not require blood and urine testing.
    - The PrecisionTerm series may offer insurance at a lower cost but may require more underwriting requirements, including a paramedical examination and blood and urine testing.
- You have read and accepted this Application Agreement.
- You understand that Primerica agents represent Primerica Life Insurance Company when selling and servicing Primerica Life insurance. Though these agents may provide services for us, they cannot
    - accept risk;
    - decide your insurability; or
    - change or cancel any conditions or terms of the Application or policy.
- If we issue a policy, it is based on:
    - all of the statements and answers you have provided in this Application; and
    - any other evidence of insurability.
- No other information – other than what is in this Application and any other evidence of insurability attached to the policy – will be considered to be part of your policy.
- The following are true and complete:
    - the information in this Application; and
    - all additions (such as health reports and amendments).
- If we issue a policy, you will review this Application and make sure that your responses are true and complete to the best of your knowledge and belief.
- Before you accept the coverage, you will review all policy and disclosure documents. These documents show any premium and benefit changes that will happen over the life of the policy.
- We rely on the information you provide to decide whether to give you a policy and the cost of that policy. If any of the Application information is false, incorrect, or incomplete, you will immediately let us know.
- If we do not approve this Application, we will send back any payment you made. It may take up to 3 weeks to process the payment.
- You understand that within 2 years from the date we issue the policy or reinstate any coverage, or if an insured dies within that time, if we find false, incomplete or incorrect information in the Application:
    - we will challenge the coverage under the policy if an insured person dies; and
    - the policy will be canceled from its beginning.

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