CICA LIFE OF AMERICA
A CITIZENS COMPANY

Superior Choice
POWERED BY ALLEGIANT WEALTH GROUP ™

APPLICATION

FACE AMOUNT: $ _____ PREMIUM AMOUNT: $ _____

Face Amount divided by 1,000 = number of units

Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Method of Payment: ☐ Direct ☐ Credit/Debit Card ☐ Electronic Funds Transfer

Is Automatic Premium Loan Desired? ☐ Yes ☐ No

1. PROPOSED INSURED INFORMATION

_____

First Name Middle Name Last Name

_____ ☐ Male ☐ Female

Date Of Birth (MM/DD/YYYY) Current Age Gender

Social Security Number: _____

2. CONTACT INFORMATION

Email Address: _____ Telephone #: _____

Physical Address (Street, City, State, Zip Code)

_____

3. POLICY OWNER INFORMATION

(if different from Proposed Insured)

_____

First Name Middle Name Last Name

Physical Address (Street, City, State, Zip Code)

_____

Email Address: _____ Telephone #: _____

Relationship: _____ Social Security Number: _____ Current Age: _____

Would you like to designate a secondary addressee (third party) to receive lapse/terminated notices? ○ Yes ○ No

SECONDARY ADDRESSEE DESIGNATION:

First Name: _____ Middle Name: _____ Last Name: _____

Email Address: _____ Home Phone #: _____ Mobile #: _____

Permanent Address: (Street, City/Region, State/Province, Postal Code, and Country)

_____

4. BENEFICIARY INFORMATION

1. PRIMARY BENEFICIARY

First Name Middle Name Last Name

Relationship: _____ Current Age: _____

2. CONTINGENT BENEFICIARY

First Name Middle Name Last Name

Relationship: _____ Current Age: _____

5. EXISTING INSURANCE:

Do you have life insurance coverage in force with CICA Life Insurance Company of America or another company? ○ Yes ○ No

REPLACEMENT INSURANCE: Is this insurance applied for intended to replace all or part of existing insurance on any proposed insured with this or any other company? ○ Yes ○ No

Company Name: _____ Policy No.: _____

To Be Completed by the Agent

Is this insurance applied for intended to replace all or part of existing insurance on the proposed insured with this or any other company? ○ Yes ○ No

Details:_____

6. HEALTH QUESTIONS:

I affirm that the answers provided below will be true and complete to the best of my knowledge and belief.

A.) Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility, receiving hospice care, or do you have any physical or mental impairment for which you need or receive assistance or supervision in performing normal activities of daily living, unable to care for yourself, or terminally ill? ☐ Yes ☐ No

B.) 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. ☐ Yes ☐ No

C.) Have you been diagnosed by a licensed member of the medical profession with more than one occurrence of any cancer, a recurrence of any cancer, metastasis of any cancer, or currently being treated for cancer (excluding basal cell or squamous cell skin cancer)? ☐ Yes ☐ No

D.) In the past 10 years, have you been medically diagnosed, for which you have not been treated by a licensed member of the medical profession, or have not taken medication for the following: uncontrolled diabetes, uncontrolled high blood pressure, stroke/TIA, paralysis, Congestive Heart Failure, heart disease, cardiomyopathy, lung disease (including COPD (Chronic Obstructive Pulmonary Disease)/emphysema), liver cirrhosis or failure, kidney (renal) failure/insufficiency, or chronic/end-stage kidney disease (including dialysis)? ☐ Yes ☐ No

E.) Have you ever been medically diagnosed, treated by a licensed member of the medical profession, or taken medication for mental disorder, disorder of the brain or nervous system, Systemic Lupus (SLE), Alzheimer's disease, dementia, brain disease, organic brain syndrome, Lou Gehrig's disease (ALS), Huntington's disease, Muscular Dystrophy, Cystic Fibrosis, Pulmonary Fibrosis, or Multiple Myeloma? ☐ Yes ☐ No

F.) In the past 2 years, have you been hospitalized 2 or more times, or have you been advised or recommended to have any tests, treatment, surgery, or hospitalization which has not been received or completed? ☐ Yes ☐ No

G.) Within the last 2 years, have you been treated for or been advised by a licensed medical professional to have treatment for alcohol, drug, opioid, or controlled substance abuse, plead guilty or been convicted of a felony or misdemeanor for any reason, or attempted suicide? ☐ Yes ☐ No

H.) Within the last 5 years have you been advised to by a licensed member of the medical profession to have an organ transplant? ☐ Yes ☐ No

Physician Name and Address: _____

Current medications, dosage(s) and usage(s): _____

ADDITIONAL REMARKS

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I affirm that all the statements on this application are true and complete to the best of my knowledge and belief and that they shall be the basis for and a part of the policy.

I understand and agree that the Company is not bound to issue a policy and has no liability unless a policy is issued, delivered, and accepted, and the first premium paid (date of receipt at the Company's office shall be considered the date of payment) while the Proposed Insured's health and other conditions affecting insurability remain as described herein.

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE: By executing this Authorization, I authorize all health care providers, plan, or clearinghouse, insurance company, pharmacy benefit manager, Medicare or Medicaid agencies, or MIB, LLC ("MIB"), or Consumer Reporting Agency that have been involved in the care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose medical records of the Proposed Insured (including but not limited to, patient histories, progress notes, test results, x-rays, and other diagnostic information) to CICA Life Insurance Company of America for the purpose of determining eligibility for payment of a claim or issuance of a policy.

This authorization includes information about mental illness and the use of drugs, alcohol and/or tobacco (excluding psychotherapy notes); prescription drug information, sexually transmitted disease, Human Immunodeficiency Virus (HIV infection), Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis, treatment, or prognosis of any physical condition.

CICA Life Insurance Company of America will not disclose information regarding specific test results for HIV and AIDS outside of the insurance company or its employees, insurance affiliates, agents, or reinsurers, except to the person tested and to persons designated in writing by the person tested. CICA Life Insurance Company of America will not furnish specific test results for exposure to the HIV infection to an insurer industry data bank if a review of the information would identify the individual and the specific test results.

I understand and agree that the hospital or doctor indicated may disclose the medical records on the Proposed Insured and the information contained in those records to CICA Life Insurance Company of America for the purpose stated above.

This information will be used by CICA Life Insurance Company of America to determine eligibility for insurance and administer coverage.

I also understand that when the medical records are disclosed pursuant to this Authorization, the medical records on the Proposed Insured and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

This Authorization will expire six months after the date the Authorization is signed.

I understand that I may revoke this Authorization at any time, except to the extent that any healthcare provider or hospital or doctor indicated above has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to CICA Life Insurance Company of America, P.O. Box 149151, Austin TX, 78714-9151.

AUTHORIZATION

By this form (or a photostatic copy of it), I hereby authorize: (i) any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, MIB, LLC ("MIB"), or other person, organization or institution that has any records or knowledge of me, my health, or my child's health (as applicable), to give to CICA Life Insurance Company of America or its reinsurers any such information and to testify as to such information, and (ii) the Company to conduct directly or indirectly one or more investigations at any time before or after any policy issuance concerning the undersigned with any sources and regarding such information as the Company deems relevant to issuance of a policy or any claims made under a policy. I further authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB or reinsurance companies or other persons or organizations performing business or legal services in connection with this application, or as may be lawfully required or as I may further authorize. I understand that such disclosures are as permitted by law.

This Authorization will expire six months after the date the Authorization is signed. I understand that I may revoke this Authorization at any time. My revocation of this Authorization must be submitted in writing to CICA Life Insurance Company of America, P.O. Box 149151, Austin TX, 78714-9151.

SIGNED AT
(City and State)

_____

PROPOSED INSURED SIGNATURE
(parent or guardian, if minor)

_____

DATE

_____

POLICYOWNER SIGNATURE
(if different from Proposed Insured)

_____

Agent Name: _____
Agent Number: _____

Agent Signature: _____
NIPR #: _____
Florida License ID Number: _____

Agent Name: _____
Agent Number: _____

Agent Signature: _____
NIPR #: _____
Florida License ID Number: _____

HOME OFFICE ENDORSEMENT - FOR HOME OFFICE USE ONLY

POLICY NUMBER: _____

ENDORSEMENTS: _____

IMPORTANT NOTICE

THIS SHOULD BE LEFT WITH THE PROPOSED INSURED/POLICY OWNER

RISK SELECTION

Information regarding your insurability will be treated as confidential. CICA Life Insurance Company of America or its reinsurers may, however, make a brief report thereon to MIB, LLC., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at *866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA02184- 8734. CICA Life Insurance Company of America or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.