Gerber Life Insurance
445 State Street • Fremont, Michigan 49412
www.gerberlife.com

Agency Application

Agent Name _Andrea Collins_____ **Agency Name**_____ **Agent #** _B1150395__

Agent Phone # _813-509-9035_____ **Agent Email** _andre.r.collins77@gmail.com_____ ☐ **Agent Split**

Application for: Individual Whole Life Insurance — **GERBER LIFE INSURANCE COMPANY**, White Plains, NY 10605

Amount of Insurance Fill in Amount between $10,000 – $50,000 (in 000's only) $_____

1. Children *under* 15 years of age to be insured:

First Name	Last Name	Middle Initial	Sex	Date of Birth Month Day Year

2. YOUR NAME: ☐ Parent ☐ Grandparent ☐ Permanent Legal Guardian (Check one)

First Name_____ Last Name_____ Middle Initial_____

Address _____ Apt. # _____ City _____

State_____ Zip_____ Phone ( ) _____

Date of Birth_____ Sex_____ E-mail _____
(Month Day Year)

SECONDARY Addressee and Address:

First Name_____ Last Name_____ Middle Initial_____

Address _____ Apt. # _____ City _____

State_____ Zip_____ Phone ( ) _____

3. BENEFICIARY: You will be the beneficiary unless you name someone else below.

Name_____ **Relationship to child**_____

4. Were any of the children born prematurely or with abnormalities at birth diagnosed by a medical professional? (Skip this question if children are more than 1 year old)..... ☐ **Yes** ☐ **No**

5. Within the past five years have any of the children listed above been treated or diagnosed by a physician for: respiratory disorder, heart disease or disorder, mental disease or disorder, or any other impairments or diseases?..... ☐ **Yes** ☐ **No**

5a. Give full details if you answered "Yes." **Use and sign separate sheet if necessary.**

Name of Child	Nature of Condition	When condition started	Does your child still have the condition?
			☐ **Yes** ☐ **No**

6. Is there any Life Insurance or Annuity policy in force on the proposed insured children? If yes, please list below...... ☐ **Yes** ☐ **No**

Child's Name_____ Company_____

Will this policy replace a Life Insurance or Annuity policy already in force on the life of the child?..... ☐ **Yes** ☐ **No**

I AGREE THAT: The above answers are true and complete to the best of my knowledge and belief. This application shall be the basis for and part of the policy. I understand that no insurance shall take effect until this application is approved and the first premium is received by Gerber Life Insurance Company during the lifetime of the insured.

Both the children and I are citizens or permanent legal residents of the United States.

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.

X _____
Your Signature Date

To the best of my knowledge is the insurance intended to change or replace any existing insurance?..... ☐ **Yes** ☐ **No**

AGPP-12-FL-A

_____
Licensed Agent

Agent's Name _Andrea Collins_____
Agent's License ID Number _W307666__

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Coverage is dependent on answers to health questions. Issuing your policy and paying your benefits may depend on the answers given in the application.

Florida law provides you with an opportunity to name a secondary addressee on your application. The Secondary Addressee and Address section on your application allows you to name another person for the purpose of notification of a past due premium payment and possible lapse of coverage.

If the Insured dies by suicide within two years from the Issue Date of the policy, or any shorter period as may be required by applicable law in the state where the policy is delivered or issued for delivery, the only amount payable by us will be the premium paid for the policy less any debt against the policy. Please refer to your policy contract for specific details regarding exclusions, limitations, benefits and shorter time frames that may vary by state.

The following notice applies to applicants in the states of AZ, CA, CT, GA, IL, ME, MA, MN, MT, NJ, NV, NC, OH, OR, and VA: To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

Benefit amounts are subject to Gerber Life insurance limits.

Policy Form GPP-12-S-FL

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

Primary Agent Name: _Andrea Collins_____ **Agent #:** _B1150395____

Agency Name: _____ **Applicant's Name:** _____

SECONDARY AGENT - AGENT SPLIT REQUEST

Please review the following outline of requirements:

- ✓ This form must be sent in at time of application in order for a split commission to be applied.
- ✓ Split Commissions are allowed between two agents only.
- ✓ The name, agent ID, and split percentage for the secondary agent must be included in the request.
  - – If the percentage of the split is missing, it will default to 50% for each agent for the life of the policy.

Please provide secondary agent information for split commissions:

First Name: _____

Last Name: _____

Gerber Life Agent ID: _____
(If agent ID is not known, write in 9999-9999)

Percent of Split: _____ **%**

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Payment Protection Option Rider

Agent Name_Andrea Collins_____ **Agent #**_B1150395_____

Gerber Life Insurance Company
445 State Street, Fremont, MI 49412

Application for Payment Protection Option

1. Your Name: _____

2. Your Date of Birth: __/__ __/__ __/__/__/__

3. Are you the person paying for the child's Grow-Up® Plan?. . . . . ☐ Yes ☐ No

4. Children insured by a Grow-Up® Policy:

_____

_____

_____

5. Are you currently disabled or have you applied for disability benefits or have you been diagnosed by a medical professional with a terminal illness? . . . . . ☐ Yes ☐ No

I AGREE THAT: The above answers are true and complete to the best of my knowledge and belief. This application shall be the basis for and part of the option/rider. I understand that no insurance shall take effect until this application is approved and the first premium is received by Gerber Life Insurance Company during the lifetime of the owner.

Both the child(ren) and I are citizens or permanent legal residents of the United States.

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.

_____ _____/_____/_____

6. Your Signature **Date**

APPO-13-FL

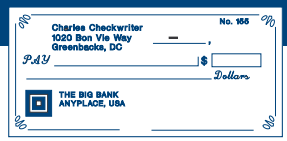
_____
Licensed Agent

Agent's Name_Andrea Collins _
Agent's License ID Number_W307666_____

- **For Owners 18-50 years of age**
- **Owner and payer must be the same**

Gerber Life will not charge your account any money until 1-3 days after your application is approved.

How to pay your premiums automatically through your CHECKING ACCOUNT:



1. Complete and sign the Authorization Form below.
2. Please provide the required financial information. Contact your financial institution for the correct account and routing numbers.
3. Your first premium will be charged 1-3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
4. Premiums will continue to be automatically withdrawn each month unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on this Form.

How to pay your premiums automatically through MASTERCARD or VISA:

1. Complete and sign the Credit Card Authorization Form below.
2. Your first premium will be charged 1-3 days after your application is approved by Underwriting unless a Preferred Payment Date has been requested.
3. Premiums will continue to be charged monthly to the credit card you select, unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on the Form.

Questions? Call our toll-free number: **1-800-428-4947** Monday-Friday, 8:30am to 6pm (EST)

Use this Authorization Form for payment by automatic withdrawal from CHECKING ACCOUNT

☐ **Yes,** I hereby authorize the bank or financial institution named below to pay my insurance premiums as indicated below, by automatic withdrawal from my checking account. **I understand that my 1st premium will not be withdrawn until 1-3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____

Insured's name: _____ **Date of Birth:** _____

Name of Financial Institution _____

Type of Account: ☐ **Checking** ☐ **Savings** **Bank Transit #** _____ **Account #** _____

X _____ **Date** _____
(Accountholder's Signature)

Preferred Payment Date _____

If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age. Payment date must be within 28 days of submission

Please automatically withdraw my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

Use this Credit Card Authorization Form for payment by MASTERCARD or VISA

☐ **Yes,** please charge my premiums to my credit card account. **I understand that my 1st premium will not be withdrawn until 1-3 days after my application is approved by Underwriting unless a Preferred Payment Date has been requested.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Please check ☑one: ☐ **Mastercard – Must contain 16 numbers** ☐ **VISA – Must contain 13 or 16 numbers**

Card Number: _____ **Exp. Date** _____

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____

Insured's Name: _____ **Date of Birth:** _____

X _____ **Date** _____
(Cardholder's Signature)

Preferred Payment Date _____

If application not approved by date selected, premium will be withdrawn on the date selected the following month. If the insured's age changes prior to selected date, the premium will be based on the new age. Payment date must be within 28 days of submission

Please charge my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

GERBER LIFE INSURANCE COMPANY • Home Office: 1311 Mamaroneck Avenue, Suite 350, White Plains, NY 10605

CONDITIONAL RECEIPT FOR UNDERWRITTEN POLICIES

THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. PAYMENT IN CASH IS NOT ACCEPTABLE.

All checks and money orders must be made payable to: GERBER LIFE INSURANCE COMPANY.

Any insurance under this Conditional Receipt will be effective from the date of the completed application, or the date of the last medical examination required by the Company's established rules, whichever is later, provided that all of the following conditions have been fulfilled:

1. The first premium is paid by the date of the completed application by check or money order that is honored and collectable; and

2. On the date of the completed application or the date of the last medical examination, if required, whichever is later, the proposed insured is insurable and acceptable for the insurance, exactly as applied for, as determined by Gerber Life Insurance Company, under its underwriting rules and practices for the plan and amount of insurance applied for and at the Company's standard premium rate.

The amount of any insurance effective under this Conditional Receipt is limited to the lesser of the amount applied for in the application or $25,000.

Any insurance under this Conditional Receipt ends at the earlier of 1) sixty (60) days from the date of the completed application, or 2) the date the policy is approved, which is the Policy Date.

If the conditions under this Conditional Receipt are not satisfied, no insurance of any kind will be in effect and the payment will be returned to the applicant.

THIS CONDITIONAL RECEIPT DOES NOT PROVIDE ANY TEMPORARY OR INTERIM INSURANCE COVERAGE.

Received from _____ the sum of $_____ paid by check or money order at the time of signing the insurance application.

The proposed insured is: _____

Date _____ Signature Andrea R Collins Agent# B1150395
Month /Date/ Year Licensed Agent

Date _____ Signature _____
Month /Date/ Year Proposed Insured

CRUW-2011

Agent Instructions:

PLEASE NOTE THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT AND A COPY MUST BE SENT TO GERBER LIFE INSURANCE WHEN THE FIRST PREMIUM IS PAID BY CHECK OR MONEY ORDER. THIS MUST BE DONE AT THE TIME OF APPLICATION. ADDITIONALLY, THE CONDITIONAL RECEIPT, APPLICATION AND THE CHECK MUST ALL HAVE THE SAME DATE.

Name of Proposed Insured:_____ **Application number:**_____

GERBER LIFE INSURANCE COMPANY

Authorization to Obtain, Use, and Disclose Personal Information (Insurance Eligibility)

PURPOSES

This authorization applies to any Personal Information (defined below) that may be obtained, used, or disclosed about the Proposed Insured by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

PERSONAL INFORMATION

I understand and agree that the types of "Personal Information" that may be obtained, used, or disclosed about the Proposed Insured on the basis of this authorization may include, to the extent permitted by law:

(i) any and all health records about the Proposed Insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,

(ii) non-health information about the Proposed Insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

AUTHORIZATION FOR OTHERS TO DISCLOSE TO US

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the Medical Information Bureau (MIB); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of Personal Information about the Proposed Insured does not apply to this authorization.**

AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

FAILURE TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

DURATION AND REVOCATION

Unless revoked earlier, this authorization will remain in effect for 24 months* from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company
ATTN: Underwriting Department
445 State Street
Fremont, MI 49412

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

COPIES OF THIS FORM

I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured. I also understand that I am entitled to obtain a copy of this authorization form.

_____ _____

Date Signature of Proposed Insured or Authorized Representative

_____

Relationship to Proposed Insured

*For residents in the state of Minnesota, unless revoked earlier, this authorization will remain in effect for 12 months from the date signed.