Bluebonnet LIFE INSURANCE COMPANY

P. O. BOX 22924 • Jackson, MS 39225-2924

APPLICATION FOR BLUEBONNET LIFE INSURANCE

Social Security No.	Last Name	First	M.I.	Basic STD	Supp. Life	Dep. Coverage
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Mailing Address	Apt. No.	City	State	Zip	Sex	Marital Status	Date of Birth
					☐ Male ☐ Female	☐ Married ☐ Single ☐ Other	

Name of Employer	Group No. / Dept No.	Area Code Phone No.
		( )

Date of Full-Time Employment	Occupation	Salary	
		$	☐ Hourly ☐ Monthly ☐ Annual

Primary Beneficiary Last Name	First	M.I.	Relationship to You	Date of Birth

Contingent Beneficiary Last Name	First	M.I.	Relationship to You	Date of Birth

I understand this information will be used by Bluebonnet Life Insurance Company to determine eligibility for insurance. I know that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the insurance provided from time to time by my employer's group insurance plans, designate the above beneficiaries, and authorize deduction from my pay the amounts, if any, made necessary. The information given herein is true and correct, to the best of my knowledge and belief.

X _____ _____

Applicant's Signature | Date

DECLINATION

I have been given an opportunity to apply for group insurance but do not wish this coverage.

X _____ _____

Applicant's Signature | Date

X _____ _____

Witness Signature | Date

IF APPLICABLE, PLEASE ANSWER ALL QUESTIONS LISTED BELOW

Has any person included in this application ever had any of the following ailments? If yes, underline ailment(s) and explain in the remarks section. Indicate by letter the question being answered.

	YES	NO
(a) Asthma, sinus trouble, bronchitis or tuberculosis	☐	☐
(b) Arthritis, rheumatism, any bodily deformity or sciatica	☐	☐
(c) Abnormal blood pressure, heart trouble, rheumatic fever	☐	☐
(d) Cancer, tumor, growth (cyst, wart, etc.)	☐	☐
(e) Diabetes, kidney or urinary system disorders or kidney stones	☐	☐
(f) Goiter, thyroid, varicose veins	☐	☐
(g) Hemorrhoids, hernia, rupture or rectal ailment	☐	☐
(h) Abnormal weight loss past year	☐	☐
(i) Seizures, epilepsy, nervous or mental disorder, fainting spells	☐	☐
(j) Irregular or excessive menstrual bleeding (female disorder)	☐	☐
(k) Gall stones, gall bladder disorder, or prostate disorder	☐	☐
(l) Ulcers, stomach trouble, appendicitis, or colon trouble	☐	☐
(m) Impairment of sight or hearing	☐	☐
(n) Excessive use or misuse of alcohol or drugs	☐	☐
(o) Blood disorder	☐	☐
(p) Muscular disease	☐	☐
(q) Any other medical or surgical advice or treatment or departure from good health within last 10 years	☐	☐
(r) Currently pregnant	☐	☐

YOUR HEIGHT:	YOUR WEIGHT:	SPOUSE'S HEIGHT:	SPOUSE'S WEIGHT:

Is anyone engaged in private flying, parachuting, hang gliding, racing or underwater diving? ☐ YES ☐ NO

Has anyone ever had any Health Insurance postponed, rated, ridered, declined, cancelled or had reinstatement refused? ☐ YES ☐ NO

Has any person included in this application been hospitalized within the past 10 years? If yes, give details below ☐ YES ☐ NO

Do you, or any of your dependents for whom you are applying for coverage, have Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? ☐ YES ☐ NO

Have you, or any of your dependents for whom you are applying for coverage, ever tested positive on an AIDS diagnostic test or been exposed to AIDS? ☐ YES ☐ NO

REMARKS: (GIVE DETAILS HERE: Include person's name, ailment, date, treatment and current condition. **Indicate by letter the questions being answered.** If more space is needed, attach a separate sheet.)

I authorize any physician, medical professional, hospital, clinic, other medical care institution, or employer having information available as to employment, other insurance coverage, medical care, advice, treatment or supplies with respect to any physical or mental condition regarding me or other family members proposed for insurance, to give the information to Bluebonnet Life Insurance Company or any agent acting on Bluebonnet Life Insurance Company's behalf. I understand this information will be used by Bluebonnet Life Insurance Company to determine eligibility for insurance. I understand this authorization is valid for two and one-half years from the date signed. I know that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. The information given herein is true and correct, to the best of my knowledge and belief.

I understand that the issuance of this contract/certificate is based on all statements and answers to questions contained herein.

X _____ _____

Applicant's Signature | Date

BLUEBONNET LIFE (FOR COMPANY USE ONLY)

Group Number	Monthly Premium	Certificate Number	Employee Class Number
B-			

Effective Date	Life Volume	AD&D Volume	Supplemental Volume	Disability Benefit