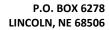


T. 800.383.1776 F. 402.483.2341

Application for Group Credit Term Life Insurance

GROUP POLICY NUMBER		OCCUPATION		EMPLOYER (NAME AND ADDRES			S)					
NAME OF INSURED 1.							EFFECTIVE DATE	TERMINAT	ION DATE	NO. OF PAYMENTS		
FIRST M.I. LAST			LAST	BIRTH DATE	AGE	SEX		LIFE BENEFITS PROVIDED				
2.								SINGLE LIFE		JOINT LIFE		
ADDRESS OF INSURED								DECREASING LEVEL		DECREASING LEVEL		
					CTATE ZID			TOTAL AMT. OF INS. \$ MO. DISABILITY BENEFIT		LIFE PREMIUM \$		
STREET TOWN FIRST BENEFICIARY – CREDITOR					STATE ZIP					DISABILITY PREMIUM		
							\$		\$			
SECOND BENEFICIARY					RELATIONSHIP			DISABILITY COVERAGE 14 DAY RETRO.		TOTAL PREMIUM \$		
HEIGHT				WEIGHT			STATE WHERE BORN					
FEETINCHES												
YES	NO	 (1) Do you have any physical or mental impairments? (2) Within the past ten years, have you ever been treated or diagnosed for, or been told you had any of the following conditions? High blood pressure; heart disease; lung disease; rheumatic fever; cancer or tumor; diabetes; tuberculosis; arthritis; stroke; epilepsy; disease of the kidney, bladder, stomach, or intestinal tract; injury or disease of the back, neck, spine, shoulder or knee; carpal tunnel syndrome; fibromyalgia? 										
		(4)	Are you employed for profit 30 hours or more per week?									
During the last 2 years, have you been absent from work for a period of more than 5 consecutive days because of illness or injury? I have read the questions and answers contained herein and represent that the answers are true, correct, and complete to the best of my knowledge and belief and that no material circumstance has been withheld or omitted. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, or of my spouse or dependent children if proposed for insurance, to give to the First National Life Insurance Company of the U.S.A. and its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The authorization shall be valid for no more than twenty-four months. I understand that I have the right to revoke the authorization at any time.												
to the Cr under th Date spe commer	editor name is application ecified in the incing date sp	ed here on until e Policy pecified	in, and that it is of it has been receiv issued hereunde	fered in connectived and approver shall be the sar ive Date specifie	ion with a credit tra d by said Company ne. If any required d in the Policy issue	nsaction . If appro evidence	betwee oved in t e of insu	en me and the Credito chirty days from the or crability is submitted	or. I agree that to commencing da to the Compa	the Company ate requeste ny more thar	y initial indebtedness shall incur no liability d above, the Effective n thirty days after the and there shall be ar	
							SIC	GNED THIS	DAY OF			
		Sign	ature of Agent				_	Signature of Applicant				





T. 800.383.1776 F. 402.483.2341

Information regarding your insurability will be treated as confidential. First National Life Insurance Company of the U.S.A. or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operate an information exchange in behalf of its members. If you apply to another Bureau member company for life or health Insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file (medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station. Boston, Massachusetts 02112, Telephone number (617) 426-3660.

First National Life Insurance Company of the U.S.A or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

In making this application for insurance to First National Life Insurance Company of the U.S.A., it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.