First National
Life Insurance Company
of the USA
Since 1908
A nelnet COMPANY

P.O. BOX 6278
LINCOLN, NE 68506

T. 800.383.1776
F. 402.483.2341

Application for Group Credit Term Life Insurance

GROUP POLICY NUMBER	OCCUPATION	EMPLOYER (NAME AND ADDRESS)				
NAME OF INSURED 1.				EFFECTIVE DATE	TERMINATION DATE	NO. OF PAYMENTS
FIRST M.I. LAST	BIRTH DATE	AGE	SEX	LIFE BENEFITS PROVIDED		
2.				**SINGLE LIFE** DECREASING ☐ LEVEL ☐	**JOINT LIFE** DECREASING ☐ LEVEL ☐	
ADDRESS OF INSURED				TOTAL AMT. OF INS. $	LIFE PREMIUM $	
STREET TOWN STATE ZIP						
FIRST BENEFICIARY – CREDITOR				MO. DISABILITY BENEFIT $	DISABILITY PREMIUM $	
SECOND BENEFICIARY	RELATIONSHIP			DISABILITY COVERAGE 14 DAY RETRO.	TOTAL PREMIUM $	
HEIGHT FEET__________ INCHES____________.	WEIGHT			STATE WHERE BORN		

*NOT ISSUED TO ANY PERSON WHO HAS PASSED HIS SIXTY-SIXTH BIRTHDAY

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?
☐	☐	(3) Have you consulted a doctor or been treated within the past 3 years for any of the conditions listed above in question (2)? For each "yes" answer, give details on Physician Information Form.
☐	☐	(4) Are you employed for profit 30 hours or more per week?
☐	☐	(5) 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.

I further represent that I signed this application for the insurance coverage designated herein, that such insurance coverage is not more than my initial indebtedness to the Creditor named herein, and that it is offered in connection with a credit transaction between me and the Creditor. I agree that the Company shall incur no liability under this application until it has been received and approved by said Company. If approved in thirty days from the commencing date requested above, the Effective Date specified in the Policy issued hereunder shall be the same. If any required evidence of insurability is submitted to the Company more than thirty days after the commencing date specified above, the Effective Date specified in the Policy issued hereunder shall be the date of such approval by the Company, and there shall be an appropriate refund or adjustment in the premium specified above.

SIGNED THIS______________DAY OF___________.

______________________________ Signature of Agent

______________________________ Signature of Applicant

First National
Life Insurance Company
of the
Since 1908 USA
A nelnet COMPANY

P.O. BOX 6278
LINCOLN, NE 68506

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.