



COTTON STATES LIFE INSURANCE COMPANY
 244 PERIMETER CENTER PARKWAY
 P.O. BOX 105303
 ATLANTA, GEORGIA 30348

POLICY CHANGE AND REINSTATEMENT APPLICATION

Florida Agent's License # _____
 Credit to: _____
 Agt No _____ Dist _____

CHANGE REQUESTED	Complete Part A for:	Complete Parts A & B for:	
Original Policy Number _____	<input type="checkbox"/> Term Conversion <input type="checkbox"/> Decrease Face Amount <input type="checkbox"/> Deletion of Benefits	<input type="checkbox"/> Policy Reissue <input type="checkbox"/> Increase Face Amount <input type="checkbox"/> Addition of Benefits	<input type="checkbox"/> Reinstatement <input type="checkbox"/> Reduction in Rating or Removal of Rider <input type="checkbox"/> Other _____

Part A

1a. PROPOSED INSURED (A)	Name _____	b. Birthdate _____	c. Birth State _____	d. Sex _____	e. S.S./Tax ID # _____	f. <input type="checkbox"/> Preferred <input type="checkbox"/> Non Smoker <input type="checkbox"/> Smoker
2a. Home Address	Street _____ City _____ County _____ State _____ Zip _____	b. Within City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Marital Status _____		
3a. Employer's Name & Address _____				b. Occupation -- Describe Duties _____		
4a. PROPOSED INSURED (B)	Name _____	b. Birthdate _____	c. Birth State _____	d. Sex _____	e. S.S./Tax ID # _____	f. <input type="checkbox"/> Preferred <input type="checkbox"/> Non Smoker <input type="checkbox"/> Smoker
5a. Home Address	Street _____ City _____ County _____ State _____ Zip _____	b. Within City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Marital Status _____		
6a. Employer's Name & Address _____				b. Occupation -- Describe Duties _____		

7a. Base Plan of Insurance	b. Old Face Amount \$ _____	c. New Face Amount \$ _____	d. Death Benefit Option (Universal Life ONLY)	<input type="checkbox"/> A - Level <input type="checkbox"/> B - Increasing
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8. RIDERS		Add	Delete	Plan	Add	Delete	Amount
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disability Waiver of Premium	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disability Income	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death Benefit	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increase Option	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

9. Balance of existing term policy (if any) to be: continued added as a rider discontinued

10. For policy reissues, the original policy will be: discontinued surrendered with all cash surrender value applied to new policy.
 The owner releases and forever discharges Cotton States Life and Health Insurance Company from all liability under the original policy.

11. PREMIUMS	a. New Planned Premium \$ _____	b. Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly Bill	c. Submitted Premium	d. Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No (If available)
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12a. OWNER - If different from Proposed Insured (A) MUST sign application	b. S.S. / Tax I.D. # _____	c. Relationship to Proposed Insured _____
d. Address Street _____ City _____ County _____ State _____ Zip _____		

13. BENEFICIARY		S.S./Tax I.D. #	Relationship	Birthdate
a. Proposed Insured (A)	Primary:			
	Contingent:			
b. Proposed Insured (B)	Primary:			
	Contingent:			

14 a. Has any person proposed for insurance smoked cigarettes within the last 12 months? Yes No

b. Has any person proposed for insurance smoked a pipe, cigarettes, cigars or used any other form of tobacco within the past 3 years? Yes No
 If yes to "a" or "b", give type and frequency.

15. In the past five years have you engaged as or do you plan to engage as a pilot, crew member, skin diver, sky diver, or auto or motorcycle racer? Yes No

16. LIFE INSURANCE IN FORCE - PROPOSED INSURED (A)				17. LIFE INSURANCE IN FORCE - PROPOSED INSURED (B)			
IF NONE STATE NONE				IF NONE STATE NONE			
COMPANY	AMOUNT	A.D.B. AMOUNT	YEAR ISSUED	COMPANY	AMOUNT	A.D.B. AMOUNT	YEAR ISSUED

18. Will this insurance replace or cause a change in any existing insurance? Yes No
 If yes, provide policy number, name of Proposed Insured, company name, type of coverage, and termination date, along with a completed REPLACEMENT FORM.

SPECIAL REQUESTS	HOME OFFICE ENDORSEMENTS
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Part B

19. The following questions are to be answered by each adult Proposed Insured and by the adult applicant for each child listed for coverage.

Name	Current Ht. & Wt.	Name and Address of Personal Physician	Reason Last Consulted and Treatment Given	Date and Duration	All Medication Currently Being Taken
Proposed Insured (A)	a.	b.	c.	d.	e.
Proposed Insured (B)	f.	g.	h.	i.	j.
Children	k.	l.	m.	n.	o.

20. Has any person proposed for insurance ever had any symptoms of or treatment for: (If "Yes", explain at Question 22.)

a. A disease or disorder of the brain or nervous system? Emotional disorder, fainting, epilepsy, convulsions or paralysis?	Yes	No	e. A disease or disorder of the stomach, intestines, rectum, pancreas, liver or gall bladder? Ulcer or rupture?	Yes	No
b. A disease or disorder of the heart or blood vessels? Chest pain? Heart attack? High blood pressure?			f. A disease or disorder of the kidney, bladder or prostate? Diabetes? Sugar or albumin in urine?		
c. A disease or disorder of the lungs? Asthma? Emphysema?			g. Cancer? Tumor? Disorder of glands or blood?		
d. A disease or disorder of the bones, joints, back or spine?			h. Any illness, disease or injury in the past 5 years not listed above?		

21. Has any person proposed for insurance: (If "Yes", explain at Question 22.)

a. Been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex), a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause? Tested positive on an AIDS related blood test?	Yes	No	b. Received treatment for the use of alcohol? Used narcotics, cocaine, marijuana, qualudes, amphetamines, barbiturates or any other habit forming drug?	Yes	No
			c. Had a parent, brother or sister with a history of heart disorders?		

22. Describe details of "Yes" answers to Questions 20 & 21. (If same answer as question 19, please indicate below.)

Name	Question #	Details of Injury, Illness or Disorder	Date	Name & Address of Physician or Hospital

Each of the undersigned represent to the best of their knowledge and belief that all statements and answers contained in this application and any medical examination which by its terms shall also be considered part of this application are complete and true and expressly agrees as follows: (1) Any insurance approved by Cotton States Life Insurance Company (the "Company") for issuance based on this application and medical examination, if required, shall be deemed in force when: (a) a policy is issued by the Company; (b) the policy is received and accepted in person by the Owner; (c) the full first premium is paid; and (d) the health and occupation of the Proposed Insured(s) remain unchanged since the completion of this application. If the insurance becomes effective prior to policy delivery as provided by the Conditional Receipt, the amount of life insurance shall not exceed the amount of life insurance shown on this application. (2) Only the president, a vice-president, or secretary of the Company can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing. No statement, representation or promise made by any other person shall be binding upon the Company. (3) The Company is authorized to amend this application in the space entitled "Home Office Endorsements" and acceptance by the Owner of any policy issued on this application shall constitute a ratification of any such amendments. However, no change in plan or amount of insurance, birthdate, rate class, or benefits will be made without written acceptance by the Owner.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, the Medical Information Bureau, consumer reporting agency or similar institution, or other organization, institution or person that has any records or knowledge of me or any member of my family applying for insurance or our health to release to Cotton States Life Insurance Company or its reinsurer(s) any and all such information it may require to determine my (our) acceptance for the insurance being requested. I know that I may request a personal interview by a consumer reporting agency. I certify I have received notification regarding the Fair Credit Reporting Act and the Medical Information Bureau. This authorization will be valid for two and one-half years from the date signed and a photocopy shall be valid as the original. I understand that I am entitled to receive a copy of this form.

NOTICE: (Does not apply in Georgia and Virginia.) Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **FLORIDA NOTICE:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

DATE: _____ Dated at - City: _____ State: _____

Signature of Proposed Insured (A) _____

Signature of Proposed Insured (B) _____

Signature of Owner (If other than Proposed Insured(s)) _____

Each application question was asked by me personally of the Proposed Insured(s) and all answers have been accurately recorded. I have witnessed the signing of this application by the Proposed Insured(s).

Will insurance applied for replace any insurance now in force?
 Yes No (If 'Yes,' complete applicable replacement forms.) _____

Agent's Name (Printed) _____ Agent's Signature _____

Agt # _____

AGENT'S REPORT
THIS REPORT MUST BE COMPLETED.

1. Do you know the Proposed Insured(s): _____ Well? _____ Casually? _____ Stranger?
2. Are you related to any Proposed Insured(s)? Yes No. If 'Yes', details: _____
3. Did you see ALL Proposed Insured(s) on date of application? Yes No. If 'No', details: _____
4. Did you ask each question on this application to each Proposed Insured and witness all signatures? Yes No.
If 'No', explain: _____

I represent that the answers above are complete and accurate to the best of my knowledge. I have given the required Conditional Receipt to the applicant for any premium received. I have complied with all disclosure regulations in my state and furnished the applicant with all required documents.

Agent's Signature: _____ Date: _____ Agent #: _____ District #: _____

AUTHORIZATION TO HONOR CHECKS DRAWN BY COTTON STATES LIFE INSURANCE COMPANY

BANK AUTHORIZATION: As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to Cotton States Life Insurance Company, Atlanta, Georgia, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. This authorization is to remain in effect until revoked by me in writing. Until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

COMPANY AUTHORIZATION: I hereby request and authorize Cotton States Life Insurance Company to make a debit transfer from my bank account by way of draft, check, or electronic transfer for the payment of premiums due on the insurance policy shown below.

Print Name _____

X _____
Bank Signature EXACTLY as it appears on Bank Records _____ Date _____

Name and Address of Bank:

Policy Number _____

Bank Account Number _____

Bank Number _____

ATTACH SAMPLE OF VOIDED CHECK

CONDITIONAL RECEIPT

Received from _____ the sum of \$ _____ in connection with this application, which bears the same date as this Conditional Receipt, for life insurance to Cotton States Life Insurance Company (the 'Company').

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS EACH AND EVERY ONE OF THE FOLLOWING FOUR CONDITIONS IS SATISFIED FULLY. NO PERSON IS AUTHORIZED TO CHANGE OR WAIVE ANY OF THESE CONDITIONS.

1. The payment received with this application must equal the amount of the full first premium according to the mode of premium payment selected in the application and for the plan and the amount of life insurance applied for.
2. All medical examinations and tests required by published Company rules must be completed within 60 days from the date of the application.
3. The Proposed Insured(s) must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and the amount of life insurance applied for, without modification and at the rate of premium paid.
4. The Proposed Insured(s) must be in good health on the Effective Date.

Insurance as provided by the terms and conditions of the policy applied for and in use by the Company on the Effective Date, but for an amount not exceeding the amount of life insurance shown on this application, will become effective as of the Effective Date.

'Effective Date' means the latest of: (a) the date of the application; or (b) the date of completion of all medical examinations and tests required by published Company rules; or (c) the date of issue, if any, requested in the application.

If one or more of the four conditions listed above have not been satisfied fully, there shall be no liability on the part of the Company except to refund the amount paid.

Date: _____ Dated at—City: _____ State: _____

**All premium checks must be made payable to Cotton States Life Insurance Company.
Do not leave payee blank or make checks payable to the agent.**

Agent's Signature _____

NOTIFICATION REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Cotton States Life Insurance Company 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 operates an information exchange on 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 in its file. •Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. • Cotton States Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

TO THE BANK NAMED ON THE REVERSE SIDE

So that you may comply with your depositor's request, Cotton States Life Insurance Company (the 'Company') agrees that:

- (1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any draft, check, or electronic transfer drawn by the Company on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such draft, check, or electronic transfer drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture, of a policy of insurance the premium on which is sought to be collected by the Company by any such draft, check, or electronic transfer; and
- (2) It will refund to you any amount erroneously paid by you on any such draft, check, or electronic transfer if claim for the amount of such erroneous payment is made by you within twelve months from the date of the draft, check, or electronic transfer on which such erroneous payment was made.

COTTON STATES LIFE INSURANCE COMPANY

Wendy M. Chambliss
Secretary

Authorized in a resolution adopted by the Board of Directors of Cotton States Life Insurance Company on March 19, 1962.

FAIR CREDIT REPORTING ACT — PRE-NOTIFICATION FORM

Thank you for considering Cotton States Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-508 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors and associates. 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 and this written request should be directed to Cotton States Life Insurance Company, P.O. Box 105303, Atlanta, GA 30348.