COLONIAL PENN LIFE INSURANCE COMPANY
399 Market St., Philadelphia, PA 19181

APPLICATION for INDIVIDUAL WHOLE LIFE INSURANCE

Source Code:
8LXZZZZZZZ

1. Proposed Insured (Please complete all information so we can process your application. Thank you!)

Name: _____
First Middle Last

Address: _____

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

Place of Birth: State/Province _____ Country _____

Occupation: _____ **Email:** _____

Telephone: (_____) _____

Gender: ☐ Male ☐ Female

Date of Birth: __ __/__ __/__ __ __ __ (mm/dd/yyyy)

Social Security Number: _____ /____ /_____

Height: ____feet ____inches **Weight:** ____ pounds

2. Beneficiary Designation (Benefit amount will be divided equally unless otherwise noted)

Beneficiary Name (Please Print)	Relationship to you	% Share
Beneficiary Name (Please Print)	Relationship to you	% Share

3. Life Insurance Benefit Amount

I wish to apply for the following benefit amount (please check one)

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

4. Personal Information (Please answer all questions so we can process your application. Thank you!)

1. Are you currently, or have you within the past 3 years used a wheelchair, used oxygen, been confined to a hospital or nursing facility, received or receiving home health or hospice care, or been disabled due to an illness? ..... ☐ **Yes** ☐ **No**

2. Have you ever had an organ transplant, been advised in the past 5 years by a member of the medical profession to have surgery which has not yet been performed or testing that has not been completed, or are you currently undergoing an evaluation or diagnostic testing for symptoms of an illness, excluding testing related to AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)? ☐ **Yes** ☐ **No**

3. Have you been diagnosed by a member of the medical profession with or received treatment for AIDS (Acquired Immune Deficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus)? ..... ☐ **Yes** ☐ **No**

4. In the past 3 years, have you been diagnosed by a member of the medical profession with, received treatment or had treatment recommended for any condition listed below? Check the box if your answer is yes. Leave it blank if your answer is no.

- ☐ Lung disease including chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, sarcoidosis or pulmonary fibrosis
- ☐ Kidney disease, kidney insufficiency, acute or chronic kidney failure or any use of dialysis
- ☐ Heart disease, including, but not limited to coronary artery disease, myocardial infarction/heart attack, cardiomyopathy, congestive heart failure (CHF), angina
- ☐ Heart surgery including coronary artery bypass grafting, angioplasty with or without stent placement, valve replacement or repair, or implantation of a pacemaker or defibrillator
- ☐ Any cancer or recurrence of cancer including, but not limited to leukemia, malignant melanoma or multiple myeloma and excluding basal cell and squamous cell skin cancers
- ☐ Liver disease, including, but not limited to hepatitis (any type), cirrhosis
- ☐ Stroke, transient ischemic attack (TIA), peripheral vascular disease, or cerebrovascular disease
- ☐ Alzheimer's disease or dementia
- ☐ Bipolar disorder, schizophrenia or psychosis
- ☐ Alcohol or drug abuse
- ☐ Diabetes requiring insulin, or hospitalization for complications of diabetes including amputation
- ☐ Multiple sclerosis, muscular dystrophy, cystic fibrosis, amyotrophic lateral sclerosis (ALS), or collagen vascular disease, including, but not limited to systemic lupus erythematosus (SLE), rheumatoid arthritis

5. Does the Proposed Insured have any existing life or annuity insurance with us or any other company?..... ☐ **Yes** ☐ **No**

6. Is this insurance intended to replace or change any existing life insurance or annuity plan?..... ☐ **Yes** ☐ **No**
If Yes, give the Name of Insurance Company (if known) _____

5. Optional Accidental Death Rider Benefit

☐ Yes, I want to apply for Accidental Death protection in the amount of:

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000