Eligible Children Proposed to be Insured – Only Children age 15 days to 18 years who qualify based on the answers to the proceeding questions are eligible for coverage.

Child 1		❑ Male ❑ Female
First Name MI		Last Name
Date of Birth	Age	SSN
Physician's Name and Phone Number ( ) -		
Amount of Insurance ❑ **$10,000** ❑ **$20,000**	Modal Premium $ _____	Policyowner's Relationship To Child ❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 3		❑ Male ❑ Female
First Name MI		Last Name
Date of Birth	Age	SSN
Physician's Name and Phone Number ( ) -		
Amount of Insurance ❑ **$10,000** ❑ **$20,000**	Modal Premium $ _____	Policyowner's Relationship To Child ❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 2		❑ Male ❑ Female
First Name MI		Last Name
Date of Birth	Age	SSN
Physician's Name and Phone Number ( ) -		
Amount of Insurance ❑ **$10,000** ❑ **$20,000**	Modal Premium $ _____	Policyowner's Relationship To Child ❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Payment Mode	**Premium**
❑ A/C (Monthly)	Child 1 $ _____
❑ Semi-Annual	Child 2 $ _____
❑ Annual	Child 3 $ _____
	Total $ _____ (Including premium from page 3)

List any additional Children Proposed to be Insured on the next Page

POLICYOWNER'S STATEMENT: I have read the completed application. The representations are true to the best of my knowledge and belief. I understand and agree that the insurance applied for shall not be in effect unless a policy is issued by the Company during the Child(ren)'s lifetime(s). I further understand and agree that any policy shall not be in effect until all eligibility requirements have been met and not until the Effective Date stated in the policy. I understand that the information on the application will be relied upon to determine insurability and that incorrect information may result in coverage being voided and the policy rescinded, subject to the policy Incontestability Provision. I understand that the agent has no right to approve the application, change any policy, or waive any policy provision. I acknowledge receipt of the Description of Information Practices.

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

_____ _____

Signature of the Policyowner Date

AGENT'S STATEMENT: I certify that I have interviewed the Policyowner, asked all of the questions contained in the application, accurately recorded the information supplied by the Policyowner, and I did not observe nor am I aware of any other information that might affect the insurability or underwriting class of the Proposed Insured(s).

Date: _____ Signature of Agent: _____ Agent #: 53243

Application Signed in: _____

City State

Family Heritage
Life Insurance Company of America

Application For **Child Whole Life** Insurance

Life Administrative Office: P.O. Box 5128, Frankfort, KY 40602-5128

Applicant/ Policyowner Information				
First Name	MI	Last Name		
Address	City	County	State	Zip Code
Phone Number ( ) -		Policyowner's e-mail Address		
Date of Birth		SSN (required)		

Beneficiary Information Unless otherwise indicated below, the Policyowner is the Primary Beneficiary		
Primary Beneficiary Name	Date of Birth	SSN (required)
Address		Relationship to Children proposed to be Insured
Contingent Beneficiary Name	Date of Birth	SSN (required)
Address		Relationship to Children proposed to be Insured

	YES	NO
1. Are all Children proposed to be Insured permanent residents of the United States or Canada?	❑	❑
2. Do any Children proposed to be Insured have existing life insurance or annuity contracts in force? (If "Yes" complete a Replacement Form)	❑	❑
3. Do you have complete knowledge of the health information for all Children proposed to be Insured?	❑	❑
4. Has any Child proposed to be Insured in the past **12 MONTHS**,		
a. been confined for 24 hours or more to a hospital, ICU, neonatal ICU or psychiatric facility excluding confinements for: normal childbirth, normal neonatal care, and conditions for which the proposed insured has completely recovered?	❑	❑
b. been advised by a medical professional to have a diagnostic test (excluding HIV and AIDS) or surgery that has not been performed or for which results have not been received?	❑	❑
c. had uncontrolled epilepsy or more than 2 seizures for any reason?	❑	❑
d. been convicted of operating a vehicle while under the influence of drugs or alcohol, been convicted of reckless driving, or had a suspended or revoked driver's license?	❑	❑
5. Has any Child proposed to be Insured in the past **10 YEARS** been diagnosed with, treated for, or taken prescription drugs for any of the following:		
a. Cancer in any form including leukemia, lymphoma, osteosarcoma and Hodgkin's disease?	❑	❑
b. Chronic bronchitis or chronic asthma (excluding mild asthma requiring occasional inhaler use)?	❑	❑
c. Heart disease, heart surgery, or uncontrolled high blood pressure?	❑	❑
d. Multiple sclerosis or systemic lupus?	❑	❑
e. Kidney disease, liver disease, chronic hepatitis, hepatitis C, or insulin dependent diabetes?	❑	❑
f. Stroke, transient ischemic attack (TIA) or mini-stroke?	❑	❑
g. Depression, bipolar disorder, alcohol or drug abuse, or any surgery or injury to the brain or spinal cord from which the Child has not fully recovered?	❑	❑
h. Down Syndrome, spina bifida, muscular dystrophy, or sickle cell anemia?	❑	❑
6. Has any Child proposed to be Insured **EVER**,		
a. been diagnosed with any immune deficiency including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	❑	❑
b. had or been advised by a medical professional to have an organ or tissue transplant; of having any illness indicated as being terminal; or of having a life expectancy of 10 years or less?	❑	❑
Do you give Family Heritage permission to show your name for marketing purposes?	❑	❑
Was the presentation for this policy delivered in Spanish?	❑	❑

Child 4

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 5

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 6

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 7

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 8

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 9

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Child 10

❑ Male ❑ Female

First Name | MI | Last Name

Date of Birth | Age | SSN

Physician's Name and Phone Number

( ) -

Amount of Insurance	Modal Premium	Policyowner's Relationship To Child
❑ **$10,000** ❑ **$20,000**	$ _____	❑ Parent ❑ Grandparent ❑ Aunt/Uncle ❑ Godparent ❑ Legal Guardian ❑ Brother/ Sister

Premium

Child 4 $ _____

Child 5 $ _____

Child 6 $ _____

Child 7 $ _____

Child 8 $ _____

Child 9 $ _____

Child 10 $ _____

Total $ _____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
INITIAL PAYMENT AND ACH AUTHORIZATION

Section 1: For Initial Payment by ACH complete sections 1 & 2. If initial premium payment is NOT made by ACH, skip Section 1 and complete Section 2.

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to deduct from the account

indicated below $_____ which represents the first monthly premium for the insurance applied for. I (we) acknowledge that this payment will be processed immediately upon the receipt of this form in Family Heritage's office and the subsequent monthly deductions will generally begin in the month following this initial premium payment.

Section 2: For All Applicants paying premium by ACH.

Draft From (check one): ❑ Checking ❑ Savings ❑ Third Party

Account in the name of:_____
(Print Name as Shown on Bank Documents)

Name of Bank and Branch:_____

City:_____State:_____

ACH Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ Account #:_____
(always 9 digits)

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to initiate entries to my (our) checking/savings account at the financial institution listed above (The Financial Institution), and, if necessary, initiate adjustments for any transaction credited/debited in error. The authority will remain in effect until Family Heritage is notified by me (us) in writing to cancel it in such time as to afford Family Heritage and The Financial Institution a reasonable opportunity to act on it. Such writing will be sent by me (us) to Family Heritage at the Executive Office in Cleveland, Ohio.

I request that such deductions be drawn from my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date_____ Signature of Bank Depositor_____