

# Missouri

## APPLICATION KIT

**Immediate Solution**  
**Easy Solution**  
**10 Pay Solution**





# EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

<b>Agent Information</b>		
Agent ID	Agent Name (Print)	Agent Phone (    )
Agent Email		Agent Fax (    )
<b>Proposed Insured Information</b>		
Insured's name (Print)		Last 4 digits of Insured's social security #
<p>Required Disclosures with Application:</p> <input type="checkbox"/> HIPPA Authorization Form <input type="checkbox"/> Bank Draft Form		
<p>Other Disclosures (if applicable):</p> <input type="checkbox"/> Accelerated Death Benefit Disclosure Form <input type="checkbox"/> HIV Consent Form <input type="checkbox"/> Replacement Form(s)		
<p>How are you paying the Initial Premium?</p> <input type="checkbox"/> By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual <ul style="list-style-type: none"> <li>• Is the check for initial premium payment on the same account as monthly EFT payments? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></li> </ul> <input type="checkbox"/> Draft initial premium upon receipt <input type="checkbox"/> Draft initial premium at future date, please indicate the month and day (mm/dd): _____ / _____ <p style="text-align: center;"><b>Month      Day (1st thru 28th only)</b></p> <ul style="list-style-type: none"> <li>• If you choose a specific Initial Premium draft date (in the future), the recurring draft date will be the same as the initial premium draft date and may not be greater than 30 days after the application date.</li> </ul> <p><b>If you select an Initial Premium Draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.</b></p> <p><b>(See 'Draft Date Procedures &amp; Scenarios' on Web site)</b></p>		
<p>Submitting Application to Monumental: <b><i>(Faxing is the preferred method)</i></b></p> <p>If faxing, fax to 1-866-834-0437 and enter date faxed _____. <b>Do Not</b> mail originals if faxing.</p> <p>If mailing the application and/or check for initial premium please send with cover sheet to:</p> <p><b>Monumental Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499</b></p>		



Agent ID #	State Application Taken	Policy # (H.O. Use Only)
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**Part A1 - Proposed Insured**

Name (First, M.I., Last)		Address, City, State, Zip Code (cannot be a P.O. Box)				
SSN	Gender	D.O.B. (MM/DD/YYYY)	Age	U.S. State or Country of Birth	Phone Number ( )	
<p>1) Within the last 12 months has the proposed Insured used tobacco products in any form? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>2) Life Insurance Face Amount \$ _____</p> <p>a) Plan: _____</p> <p>b) Accidental Death Benefit Rider Face Amount \$ _____</p> <p>c) Total Premium \$ _____</p> <p>d) If a policy cannot be issued as applied for, would you accept a rated policy if available? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>e) If 'yes,' adjust face amount to premium? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>3) Does the applicant have any existing life insurance or annuity contracts with the company or any other company? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>4) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? (If yes, submit the state required forms) <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>						

**Part A2 - Owner (If Other Than Proposed Insured)**

Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)			Are you a citizen of the U.S.? If not, what country?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part A3 - Beneficiary**

Primary Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)
Contingent Name (First, MI, Last)	SSN	Gender	Relationship to Insured	D.O.B. (MM/DD/YYYY)

**Part B1 - If Any Question In This Section Is Answered "Yes," The Proposed Insured Is Not Eligible For Any Coverage.**

<p>1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, receiving hospice or home health care, confined to a wheelchair, been advised or planning to have inpatient surgery or currently waiting for an organ transplant? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>2) Has the proposed Insured <b>ever</b>:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's disease, senile dementia, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Down's Syndrome, Huntington's disease, sickle cell anemia, Spina Bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal medical condition? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>3) Within the past <b>2 years</b> has the proposed Insured:</p> <p>a) Been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>b) Undergone testing by a medical professional for which the results have not been received? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>	
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**Part B2**

<p>4) Has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for diabetes (other than gestational diabetes) before the age of 18? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>5) Within the past <b>4 years</b> has the proposed Insured been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>6) Within the past <b>1 year</b> has the proposed Insured:</p> <p>a) Used illegal drugs or been diagnosed with, been treated for or advised to receive treatment for alcohol abuse, drug abuse or muscular dystrophy? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>b) Had more than 12 seizures or been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>c) Been diagnosed with, been treated for or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, or had or been advised to have heart surgery of any kind including bypass surgery or pacemaker implant? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>d) Used oxygen to assist in breathing due to a disease or disorder, received kidney dialysis or been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>	
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- If All Questions in Part B2 Are Answered "No," Proceed to Part B3.
- If One Question in Part B2 Is Answered "Yes," The proposed Insured Is Eligible For The Graded Death Benefit Product. Proceed to Part C1.
- If Two Or More Questions in Part B2 Are Answered "Yes," The proposed Insured Is Not Eligible For Any Coverage.



**Agent's Report**

I represent that:

- 1) I have personally seen the proposed Insured.     Yes     No
- 2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured.     Yes     No

Is the person proposed for insurance related to you?     Yes     No      Relationship \_\_\_\_\_

Is the policy applied for in this application intended to replace any insurance or annuity now in force?     Yes     No

Best time to call for a Personal History Interview    \_\_\_\_\_ a.m.    \_\_\_\_\_ p.m.

Home or work phone number \_\_\_\_\_

Agent Signature \_\_\_\_\_

**AGREEMENT / AUTHORIZATION**

This application consists of all Parts A, B, and C, and is not a contract of insurance. A contract of insurance shall take effect only if a policy is issued on this application and the first premium is paid in full (a) during the lifetime of the proposed Insured and (b) while there is no change in the insurability and health of the proposed Insured from that stated in this application. It is represented that all statements and answers in this application are true, full and complete and bind all parties in interest under any policy applied for. Only an authorized officer of our Company can make void, waive or change any of the conditions or provisions of any application, policy or receipt or accept risks or pass on insurability. Acceptance of any policy issued on this application shall mean acceptance of any change, correction, addition or amendment noted by any amendments and corrections. The proposed Insured shall be the policyowner unless another owner is named above. The Company, within sixty days of the date hereof, shall notify the prospective Insured whether or not the application has been accepted or else give the prospective Insured the reason for delay.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt. I hereby authorize any licensed physician, medical practitioner, or the Medical Information Bureau or other institution that has any records or knowledge of the proposed Insured to give any such information, including medical information, to the life insurance company. A photocopy or facsimile of this authorization shall be made as valid as the original.

**FRAUD WARNING:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at City \_\_\_\_\_ State \_\_\_\_\_      Proposed Insured Signature \_\_\_\_\_

Date \_\_\_\_\_      Owner Signature \_\_\_\_\_  
(If Owner other than Insured)

Witness \_\_\_\_\_      \_\_\_\_\_  
(Agent Signature)      (Print Agent's Name and I.D. Number)

**If The EFT Premium Payment Method Is Chosen, Please Tape A Voided Check In This Box.**

### NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

### MONUMENTAL LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

### MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Monumental Life Insurance Company, or its reinsurers may also release information from 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. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

7/08

### CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

#### Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company;
2. An amount equal to the first full premium required is paid on the plan and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates or amount of coverage.

#### Effective Date

If all of the above conditions are met, insurance in the amount applied for or \$25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or the application contains a material misrepresentation, or if the proposed Insured dies by suicide while sane or insane while this conditional receipt is in effect, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

**Agent Instructions: Please leave this page with the Proposed Insured/Owner**



**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

Parent       Legal guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): \_\_\_\_\_

**A copy of this authorization will be considered as valid as the original.**

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

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Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
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1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

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- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
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Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

Parent       Legal guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): \_\_\_\_\_

**A copy of this authorization will be considered as valid as the original.**



4333 Edgewood Rd. NE, Cedar Rapids, IA 52499

Initial and/or Recurrent Billing Authorization Form

I, the undersigned Cardmember, hereby authorize Monumental Life Insurance Company (MLIC) to charge my Visa or Mastercard account specified below, as updated from time to time by you or your card issuer, ("Card Account") any premium amounts due during the applicable billing cycles for insurance products purchased by me from MLIC unless and until MLIC has received notification in writing from me that I have withdrawn such consent and permission. I also authorize Visa or Mastercard to advise MLIC of any changes to the status of the Card Account, including updated account number and expiration date information, to ensure my uninterrupted service by MLIC.

**INITIAL PREMIUM**

- Draft initial premium upon receipt
- Draft initial premium at future date as indicated \_\_\_\_\_ / \_\_\_\_\_  
mo day

**RECURRING PAYMENTS – Complete the Following Information for Future Recurring Payments**

- New Authorization  Credit/Debit Card Update
- Billing Date (only select one box)
- Bill credit/debit card listed on day of the month matching the policy's effective day (this will be elected if option is chosen)
- Bill credit/debit card on a different day of the month; choose a day between 1 and 28 \_\_\_\_\_

**CREDIT/DEBIT CARD ACCOUNT INFORMATION**

_____ Visa or Mastercard Account No.	
_____ Cardmember Signature	_____ Date
_____ Card Expiration Date	_____ Mo./Yr.
_____ Cardmember Name (Please Print)	