Agent Instruction for Submitting New Application

In addition to the insurance application, the following forms may be required at time of application and should be submitted at the same time as the application:

Supplement to an Application for Individual Endowment Policy-if owner is different than insured

Replacement Form[1]- If Gerber Life policy will replace another policy, complete appropriate state required form. Form must be submitted with application.

NAIC-Replacement Sales/Marketing Materials Form - In compliance with the NAIC Model Replacement Act, if the Gerber Life policy will replace another policy, the Replacement Sales/Marketing form must be completed. Commissions will be withheld until the document is received.

Payment Authorization Form- For automatic payment from Checking or by Credit Card, complete ACH-AP form. ***NOTE*:** When setting up payments to be withdrawn, specific draft dates for the first payment cannot be honored. Once first payment has drafted after issuance of policy, the agent or customer can call in to change the bill date for future drafts. **Checks and money orders not accepted at time of application for this product**.

*In KS if authorization of payment is collected with the application, please provide the Temporary Insurance Receipt TIR-2015-KS to customer and submit a copy of the receipt with the application and payment. The receipt must be signed by the agent.

Split Commissions - Split commissions are allowed between 2 agents. Check off Agent Split near the upper right-hand corner of the application. Fill out the Agent Split Request Form located in this kit.

(CA Only) Disclosure to Seniors - If individual is age 65 or older and agent is meeting in their home, provide completed form to individual. A copy should be kept on file (Do Not send to Gerber Life).

(NY Only) Definition of Replacement - Replacements are not allowed in New York, although the Definition of Replacement form must be filled out for all life insurance applications. The document must be signed by the Applicant and the Agent, and a copy left with the Applicant. This document must be returned to the Company with the application. The signed date on the form must be the same signed date as the application.

(NY Only) I Certify Form – In compliance with NY state law, submission of the completed 'I Certify Form' is required to be sent with your application packet verifying your adherence to NY PIF and BG process. Commissions will be withheld until the document is received.

(NY Only) Agent Best Interest Certification – In compliance with NY Regulation 187, it is required that agents act in their customers best interest. This form is a certification that the product selected is in the best interest of the customer. This form must be signed and submitted with all NY applications. Failure to comply will result in the application being closed out.

(NY Only) Producer Checklist – In compliance with NY Regulation 187, agents are required to retain documentation related to recommendations made to a customer regarding life insurance products. This form is for your records only and is not to be submitted with applications.

(NY Only) Life Suitability and Best Interest Questionnaire – In compliance with NY Regulation 187, agents are required to determine the suitability of a product(s), prior to making a recommendation to the customer. This questionnaire is required to establish product suitability in accordance with the NY Regulation 187. One form is required per policy and is owner specific *(you cannot list multiple insureds on one questionnaire.)* This form is required to be completed in full and failure to comply will result in the application being closed out.

• Please follow your Marketing Office procedures for application submission to Gerber Life.

[1] *Replacements are not accepted in following states: CA, DE, FL, ID, IL, KY, MA, NY, PA, PR, TN, WA*

Application for Individual Endowment Policy **Gerber Life Insurance Company 1311 Mamaroneck Avenue, White Plains, NY 10605**

Select Amount: ❑ **$10,000** ❑ **$25,000** ❑ **$50,000** ❑ **$100,000** ❑ **$150,000** ❑ **Other** _____ **(enter amount between $10,000 and $150,000)**

Select Maturity: ❑ **10 Years** ❑ **15 Years** ❑ **18 Years** ❑ **Other** _____ **(enter number between 10-20)**

Select Payment Type: ❑ **Installment Payments (Premiums)**

SEND NO MONEY NOW!

INSURED Must be at least 18 years old

Full Name _____ Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___
(Last) (First) (Middle Initial)

Address_____ Apt#_____ City _____ State _____ Zip_____

Email _____ Preferred Telephone Number ( )_____

Sex_____ Height_____ ft. ____ in. Weight_____ lbs. Date of Birth _____
(Month Day Year)

Occupation _____If none, source of income_____

❑ Check box if owner is different from insured. If different please provide Full Name _____
(Last) (First) (Middle Initial)

BENEFICIARY: Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name: Relationship:

1) In the past 5 years, have you: been hospitalized or consulted with or examined or treated by any doctor or health facility? *(You do not need to include colds, minor viruses, or minor injuries which prevented normal activities for a period of less than 5 days or normal pregnancy or childbirth.)* ..... ☐ **Yes** ☐ **No**

2) In the past 5 years, have you: been advised by a member of a medical profession to reduce the use of alcohol or to seek treatment for the use of alcohol or drugs, or used any controlled substance except as prescribed by a physician? ..... ☐ **Yes** ☐ **No**

3) In the past 5 years have you plead guilty to or been convicted of a felony or misdemeanor, or do you have such a charge currently pending against you or are you currently on probation or parole? ..... ☐ **Yes** ☐ **No**

4) In the past 10 years, have you been treated or diagnosed by a member of a medical profession for a disease, disorder or condition below:

Heart ..... ☐ **Yes** ☐ **No**	Diabetes ..... ☐ **Yes** ☐ **No**	High Blood Pressure ..... ☐ **Yes** ☐ **No**
Mental or Nervous Disorder ..... ☐ **Yes** ☐ **No**	Kidney ..... ☐ **Yes** ☐ **No**	Liver ..... ☐ **Yes** ☐ **No**
Lung ..... ☐ **Yes** ☐ **No**	Cancer or Tumor ..... ☐ **Yes** ☐ **No**	Swollen Lymph Nodes ..... ☐ **Yes** ☐ **No**
Stroke ..... ☐ **Yes** ☐ **No**	Blood ..... ☐ **Yes** ☐ **No**	Brain, Spine, Nerves ..... ☐ **Yes** ☐ **No**
Stomach ..... ☐ **Yes** ☐ **No**	Intestines ..... ☐ **Yes** ☐ **No**	
AIDS (Acquired Immune Deficiency Syndrome) ..... ☐ **Yes** ☐ **No**		
HIV (Human Immunodeficiency Virus) infection ..... ☐ **Yes** ☐ **No**		

Give full details if you answered "Yes" to any question above and list each condition. ***(Use and sign separate sheet if necessary.)***

Nature of Condition	When Condition Started	Do you still have the condition?
		☐ **Yes** ☐ **No**

5) Do you have any existing life insurance or annuity contract? ..... ☐ **Yes** ☐ **No**
If yes, please complete the information below.

Company Name	Amount	Policy #	Year Issued

6) Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application? ... ☐ **Yes** ☐ **No**

It is understood and agreed that:

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

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.

I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, consumer reporting agency, or other organization or person that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

X **Insured's Signature** _____ **City/State** _____ **Date**_____

Replacement Questions to be answered by Agents:

1) Does the proposed insured have any existing life insurance or annuity contracts?. . . . . ☐ **Yes** ☐ **No**

2) Has any life insurance or annuity contract either in force or applied for on the proposed insured terminated or is termination of such insurance contemplated as a result of the insurance of the life insurance contract applied for?. . . . . ☐ **Yes** ☐ **No**

If the answer to either question is yes, have you complied with the requirements of the Company and your state with regard to this replacement? ☐ **Yes** ☐ **No** (Give full details under Remarks.)

Remarks:_____

_____
Agent Signature

MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber 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. If you question the accuracy of the information in 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 Park, Suite 400, Braintree, Massachusetts 02184-8734.

Gerber Life Insurance Company, or its reinsurers, may also release information from its file to other 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.

MIB-14

Your Rights under the Fair Credit Reporting Act

Depending on the size of the policy applied for, we may request that an investigative consumer report about the Proposed Insured be given to us. It will be conducted by a national organization skilled in obtaining information about people. A credit report may be requested in connection with this application to determine eligibility of insurance or premium to be charged.

The kind of information we may be seeking includes such facts as residence verification, marital status, occupation, general reputation, personal characteristics and mode of living. It will be obtained through personal interviews with the Proposed Insured's friends, neighbors, associates and other acquaintances. Inquiries will not be directed toward determining the Proposed Insured's sexual orientation.

The Proposed Insured, upon written request, will be informed whether or not an investigative report was requested, and if a report was ordered, the name and address of the Consumer reporting agency. A copy of this report is available to the Proposed Insured upon request.

The following notice applies to applicants in the states of AZ, CA, CT, GA, IL, ME, MA, MN, MT, NJ, NV, NC, OH, OR, and VA: To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

Benefits, Exclusions and Limitations

No physical exam is necessary in most cases. Coverage is dependent on answers to health questions, and a physical may be necessary for applicants age 51 and older and applying for more than $100,000 of coverage. If the insured dies by suicide within two years from the issue date, the only amount payable will be the premiums paid for the policy, less any debt against the policy.

Benefit amounts are subject to Gerber Life insurance limits.

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Payment of benefits under the endowment policy is the obligation of, and is guaranteed by, Gerber Life Insurance Company. Guarantees are based on the claims paying ability of Gerber Life.

Policy form series ICC10-SPIE and ICC09-PIE

Agent Information Form

AGENT INFORMATION Must be Completed by Agent

Agent Name_____ **Agency Name**_____

Agent #_____ **Agent Phone #**_____

Agent Email _____ **Applicant Name** _____

Please review the following outline of requirements:

✓ This form must be sent in at time of application in order for commission to be applied.

✓ Agent Name, Agency Name, Agent #, Agent Phone #, Agent Email, and Applicant's Name must be included on the form.

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

Primary Agent Name: _____ **Agent #:** _____

Agency Name: _____ **Applicant's Name:** _____

SECONDARY AGENT - AGENT SPLIT REQUEST

Please review the following outline of requirements:

- ✓ This form must be sent in at time of application in order for a split commission to be applied.
- ✓ Split Commissions are allowed between two agents only.
- ✓ The name, agent ID, and split percentage for the secondary agent must be included in the request.
  - – If the percentage of the split is missing, it will default to 50% for each agent for the life of the policy.

Please provide secondary agent information for split commissions:

First Name: _____

Last Name: _____

Gerber Life Agent ID: _____
(If agent ID is not known, write in 9999-9999)

Percent of Split: _____ **%**

SUPPLEMENT TO AN APPLICATION FOR INDIVIDUAL ENDOWMENT POLICY

Gerber Life Insurance Company
[1311 Mamaroneck Avenue]
[White Plains, NY 10605]

This form is a supplement to the application for an Individual Endowment policy on the following proposed insured:

First name:_____ Middle name:_____ Last name:_____

The owner of the Individual Endowment policy is to be:

First name:_____ Middle name:_____ Last name:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Telephone number:_____ Social Security Number_____

It is understood and agreed that:

All statements and answers made in all parts of the application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued shall not take effect until it is approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

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.

Owner's Signature:_____ City/State: _____ Date:_____

ICC09-AIESUPP

Name of Proposed Insured:_____ **Application number:**_____

GERBER LIFE INSURANCE COMPANY

Authorization to Obtain, Use, and Disclose Personal Information (Insurance Eligibility)

PURPOSES

This authorization applies to any Personal Information (defined below) that may be obtained, used, or disclosed about the Proposed Insured by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

PERSONAL INFORMATION

I understand and agree that the types of "Personal Information" that may be obtained, used, or disclosed about the Proposed Insured on the basis of this authorization may include, to the extent permitted by law:

(i) any and all health records about the Proposed Insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,

(ii) non-health information about the Proposed Insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

AUTHORIZATION FOR OTHERS TO DISCLOSE TO US

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the Medical Information Bureau (MIB); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of Personal Information about the Proposed Insured does not apply to this authorization.**

AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

FAILURE TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

DURATION AND REVOCATION

Unless revoked earlier, this authorization will remain in effect for 24 months* from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company
ATTN: Underwriting Department
445 State Street
Fremont, MI 49412

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

COPIES OF THIS FORM

I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured. I also understand that I am entitled to obtain a copy of this authorization form.

_____ _____

Date Signature of Proposed Insured or Authorized Representative

_____

Relationship to Proposed Insured

*For residents in the state of Minnesota, unless revoked earlier, this authorization will remain in effect for 12 months from the date signed.

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

GERBER LIFE INSURANCE COMPANY
1311 Mamaroneck Avenue
White Plains, NY 10605
800-253-3074

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

   ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

   ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant and the policy or contract number if available) and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

I certify that the responses herein are, to the best of my knowledge, accurate:

_____
Applicant's Signature and Printed Name Date

_____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older -- are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid, you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

Gerber Life Insurance Company
445 State Street, Fremont, Michigan 49412
www.gerberlife.com

REPLACEMENT

SALES/MARKETING FORMS

APPLICANT NAME: _____

APPLICATION STATE: _____

AGENT NAME: _____

AGENT#: _____ **AGENCY:** _____ **DATE:** _____

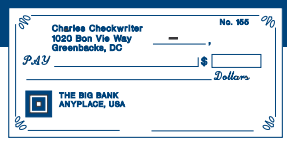
In compliance with NAIC Model Replacement Act, listed below are the Marketing/Sales forms used in the sale of this application:

Please use full Gerber Life Form# shown at the bottom of the Marketing/Sales material

Form # _____
Form # _____
Form # _____
Form # _____
None _____

Gerber Life will not charge your account any money until 3 days after your application is approved.

How to pay your premiums automatically through your CHECKING ACCOUNT:



1. Complete and sign the Authorization Form below.
2. Please provide the required financial information. Contact your financial institution for the correct account and routing numbers.
3. Your first premium will be withdrawn 3 days after your application is approved by Underwriting. Please be sure that your checking account is adequately funded. *Please Note: For the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.*
4. Premiums will continue to be automatically withdrawn each month unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on this Form.

How to pay your premiums automatically through MASTERCARD or VISA:

1. Complete and sign the Credit Card Authorization Form below.
2. Your first premium will be charged 3 days after your application is approved by Underwriting. *Please Note: For the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.*
3. Premiums will continue to be charged monthly to the credit card you select, unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on the Form.

Questions? Call our toll-free number: **1-800-428-4947** Monday-Friday, 8:30am to 6pm (EST)

Use this Authorization Form for payment by automatic withdrawal from CHECKING ACCOUNT

☐ **Yes,** I hereby authorize the bank or financial institution named below to pay my insurance premiums as indicated below, by automatic withdrawal from my checking account. **I understand that my 1st premium will not be withdrawn until 3 days after my application is approved by Underwriting and for the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

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

Insured's name: _____ **Date of Birth:** _____

Name of Financial Institution _____

Type of Account: ☐ **Checking** ☐ **Savings** **Bank Transit #** _____ **Account #** _____

X _____ **Date** _____
(Accountholder's Signature)

Please automatically withdraw my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**

Use this Credit Card Authorization Form for payment by MASTERCARD or VISA

☐ **Yes,** please charge my premiums to my credit card account. **I understand that my 1st premium will not be charged until 3 days after my application is approved by Underwriting and for the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Please check ☑one: ☐ **Mastercard – Must contain 16 numbers** ☐ **VISA – Must contain 13 or 16 numbers**

Card Number: _____ **Exp. Date** _____

Name _____
Last Name First Name Middle Initial

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____

Insured's Name: _____ **Date of Birth:** _____

X _____ **Date** _____
(Cardholder's Signature)

Please charge my premiums every (check ☑one): ☐ **month** ☐ **3 months** ☐ **6 months** ☐ **12 months**