Application for Individual Life Insurance (Please Print, use black or blue ink)

Trinity Life Insurance Company (TLIC), 7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133

Telephone Interview Completed: ❐ Yes ❐ No
[(800) 604-6844]

1. Full Name of Proposed Insured: First ________________________ MI ________ Last ________________________
   Sex:_____ Date of Birth:______/______/______ State of Birth:_______ Age:_______ SSN:_______-_______-_______ Marital Status: ____________
   Residence Address: ____
   Street City State Zip Code
   Home Phone:____________________ Work Phone:____________________ E-Mail:____________________

2. Owner: Name________________________ SSN or TIN: _______-_______-_______ Phone:____________________
   Address________________________ Relationship:____________________

3. Send Premium Notices to: ❐ Insured ❐ Owner ❐ Other (If Other, Name) ____________________
   Address:________________________ Relationship:____________________
   Street City State Zip

4. Beneficiaries:
   Primary________________________ Relationship______________ Date of Birth______________ SS#______________
   Contingent________________________ Relationship______________ Date of Birth______________ SS#______________

5. Plan Applied For: ❐ Simplified ❐ Graded ❐ Non-Tobacco ❐ Tobacco APL: ❐ Yes ❐ No ❐ Annual ❐ Semi-Annual ❐ Quarterly ❐ Monthly EFT
   Face Amount: $______________ Modal Premium: $______________ Premium Collected: $______________ ❐ None – Draft First Premium
   If Monthly, Draft Date ___ /____ / ___ (1st – 28th) or ❐ 2nd Wed. ❐ 3rd Wed. ❐ 4th Wed. Requested Effective Month______________ Yr__________

6. Does the Proposed Insured and/or Owner have any existing life insurance or annuity coverage? ❐ Yes ❐ No
   Will any existing insurance or annuity policy with another company be discontinued or changed if the insurance applied for is issued? ❐ Yes ❐ No
   (If yes, give details.) Company: ____________________ Policy #: ______________ Coverage Amount: _________ Year Issued______

7. Has any other life insurance company declined to issue, reinstate or renew, rated, modified, postponed, or cancelled any life insurance on the Proposed Insured? ❐ Yes ❐ No (If yes, provide details in remarks section below.)

8. Is the Proposed Insured a United States citizen? ❐ Yes ❐ No Is the Owner a United States citizen? ❐ Yes ❐ No

9. Proposed Insured's Height ______________ Weight ______________ In the Past year any ❐ gain ❐ loss ______________ lbs.

10. Have you used tobacco or nicotine products in any form in the past 12 months? ❐ Yes ❐ No

11. Have you ever received or been given medical advice by a medical professional you need to receive an organ or tissue transplant? ❐ Yes ❐ No

12. Have you been diagnosed or treated by a member of the medical profession as having: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV (Human Immunodeficiency Virus) virus? ❐ Yes ❐ No

13. Have you ever been diagnosed with a terminal illness, end stage disease, congestive heart failure or cardiomyopathy? ❐ Yes ❐ No

14. Have you ever been diagnosed with, treated for or taken medication for: dementia, Alzheimer's disease, mental incapacity, Downs Syndrome, Huntington's disease, Lou Gehrig's Disease (ALS), cystic fibrosis, cerebral palsy, muscular dystrophy, or sickle cell anemia? ❐ Yes ❐ No

15. Are you currently, or within the past 6 months have you been: hospitalized, bedridden, used oxygen to assist in breathing, confined to a wheelchair, nursing home, hospice, received home health care or been on dialysis? ❐ Yes ❐ No

16. Within the past 12 months have you been diagnosed as having, or been hospitalized for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind to improve circulation to the heart or brain? ❐ Yes ❐ No

17. Within the past 12 months have you been: hospitalized two or more times, or been advised by a medical professional to have surgery, hospital confinement, or nursing facility confinement and have not done so? ❐ Yes ❐ No

18. Within the past 24 months have you been diagnosed as having, treated by a medical professional for or taken medication for: internal cancer, leukemia, or melanoma? ❐ Yes ❐ No

19. During the past 24 months have you been: advised by a medical professional to have any diagnostic testing recommended, except for an HIV test, which has not been completed, or for which the results have not yet been received, or had or been advised to have treatment or counseling for alcohol or drug abuse. ❐ Yes ❐ No

20. During the past 24 months have you been treated by a medical professional for insulin shock, diabetic coma, amputation caused by disease, or have you ever taken insulin shots prior to age 40? ❐ Yes ❐ No

If any answers to questions 11-20 are "YES", Proposed Insured is not eligible for any coverage.

21. During the past 24 months have you begun prescribed medication for, been hospitalized for, or been diagnosed as having: hepatitis B or C, kidney insufficiency or failure, heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind to improve circulation to the heart or brain? ❐ Yes ❐ No

22. Have you ever been diagnosed as having: multiple sclerosis, epilepsy, Parkinson's, systemic lupus, cirrhosis of the liver, liver disease, liver failure or lung impairments (including chronic obstructive pulmonary disease (COPD), chronic asthma, chronic bronchitis, emphysema or fibrosis)? ❐ Yes ❐ No

If any answers to questions 21 - 22 are "YES", Proposed Insured may qualify for Graded Death Benefit.

Please underline the specific impairment/disease for any question answered yes, specify question number and provide details below.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned declares that:

a. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or for the Insurance Company to determine its obligations under the policy issued in connection with this application.
b. The Insurance Company, its reinsurers, insurance support organizations, consumer reporting agencies and their authorized entities may obtain data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information.
c. I authorize any licensed physician, doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, MIB, Inc., viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other organization, institution or person, that has any records or information about me to release such records or information to the Insurance Company and its reinsurers when this authorization or a copy of it is shown. All sources but the MIB, Inc. may give such records or information to agencies that the Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment or enrollment on whether this Authorization is signed.
d. Any request by the Insurance Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
e. Data about mental illness, alcoholism, sexually transmitted diseases and the use of drugs are to be included.
f. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.
g. This authorization is good for 24 months after it is signed.
h. The Insurance Company may obtain an investigative consumer report ("inspection report") on me. ❒ Yes, I want to be interviewed if such a report is obtained.
i. I have read this authorization and know my authorized representative or I may request a copy of it. I may revoke this authorization by writing to the Insurance Company.

ACKNOWLEDGEMENTS: I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. Any material misrepresentation or misstatement contained herein may render any policy issued as a result of this application void from its inception. I agree the policy shall not be in effect until it has been issued by Trinity Life Insurance Company ("the Company") and the initial premium has been paid I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice. ❒ Yes ❒ No

I also acknowledge that I paid the Agent $__________in initial premium in exchange for the Conditional Receipt attached to this application. ❒ Yes ❒ No
I also acknowledge receipt of the Accelerated Benefit Rider Summary and Disclosure Statement. ❒ Yes ❒ No

FRAUD NOTICE: 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.

Signature of Proposed Insured:______________________________________ Date:______________________

Signature of Proposed Owner (if other than Insured):__________________________ Signed at:(City & State)______________

AGENT CERTIFICATION: I certify that I have asked the Proposed Insured all of the questions on this application and have accurately recorded them. I also certify that replacement of existing insurance ❒ is ❒ is not involved.
Is any agent a relative of the Proposed Insured? ❒ Yes ❒ No Relationship:________________Send Policy to: ❒ Agent ❒ Owner

Agent: ______________________________Agent Code:________Agent Signature:__________________________ % ________

Agent: ______________________________Agent Code:________Agent Signature:__________________________ % ________

AUTHORIZATION TO HONOR CHECKS AND EFTs DRAWN BY TRINITY LIFE INSURANCE COMPANY

As a convenience to me, I hereby request and authorize Trinity Life Insurance Company (TLIC) to pay and charge to my account checks and electronic fund transfers (EFTs) drawn on my account by and payable to the order of TLIC provided there are sufficient collected funds in my account to pay such checks and EFTs upon presentation. I agree that TLIC's rights in respect to each check and EFT shall be the same as if it were a draft drawn on you and signed personally be me. This authority is to remain in effect until revoked by me in writing, and until TLIC actually receives such notice. I agree that TLIC shall be fully protected in honoring any such check or EFT.

I further agree that if any such check or EFT is dishonored, whether with or without cause and whether intentionally or inadvertently, TLIC shall have no liability whatsoever even though such dishonor results in the forfeiture of insurance. Please print information below for bank account to be charged.

Depositors' Name as Shown on Bank Account:____ ❒Checking

Insured's Name if Different than Depositor:____ ❒ Savings

Bank Name:______________________________ Bank Address______________________________________

Routing Number:______________________________

Account Number:______________________________ Signature:______________________________ Date Signed:________

PLEASE ATTACH A VOIDED CHECK TO THIS AUTHORIZATION. Signature(s) must be the same as on signature card at bank.

BANK INDEMNIFICATION AGREEMENT

To the bank addressed above: So that you may comply with your depositor's request Trinity Life Insurance Company (the Company) agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions taken pursuant to your agreement to honor any check or electronic fund transfer (EFT) executed by this Company for the purpose of payment of insurance premiums.
2. That in the event any such check or EFT is dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss.
3. To defend at our own cost and expense any such action brought against you by any depositor or other person because of your actions pursuant to this agreement.
4. To refund you any amount erroneously paid to this Company on such check or EFT if claim is made within one month of the date of the check.

This agreement has been authorized in a resolution adopted by the Company's Board of Directors.

Gregg Zahn, President