Great western application
(takes direct express on e app**,** not an option for paper app**)**
Min face: $1000
Max face: $35,000
Age range: 50-80
No ht and wt requirements

Filling Out Application
Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes.
Always make a duplicate copy of file ***BEFORE*** filling out application with client info
Retitle file with clients first and last name
Fill out yellow highlighted boxes with client info
We use GWIC as a last resort level coverage option
Client may answer no to all health question as long medication has stayed the same or decreased over the last two years, no exceptions. Current cancer or dialysis will not qualify
Questions in section H. and I. for replacement need to match.
If "yes" to existing insurance question, a replacement form needs to be filled out **even if it no replacement is occurring**
When filling out replacement page, you only need to fill out replaced insurance company **IF you are replacing**

How to Quote with Cardinal Quoting App

Level : (will be towards bottom of the list)
Underwriting Type: Full
Product Type: Level

Great Western Insurance Compa…

Assurance Plus (Adjusted for 125% UDB…

Premium:	$64.91/mo*
Face Value:	$10,000.00
Annual Fee:	$35.00

Guaranteed Issue: (only use over AIG if face amount is to small for AIG)
Underwriting Type: Guaranteed
Product Type: return of premium

Great Western Insurance Compa…

Guaranteed Assurance

Premium:	$127.91/mo*
Face Value:	$10,000.00
Annual Fee:	$35.00

Post sale interview process:
Great western does not offer a point of sale interview process. You must submit application then great western will call client at a later time and ask all health question as well as review medications. Make sure they know to say no to all health question if medications have decreased or stayed the same over he last two years.
Print a few copies of pages below titled: **Great western interview prep** to leave with the client to help guide them through the interview. Write all medications and dosage/duration they have been taking them.

How to Submit App
Delete instruction page before submitting
Fax: 517-247-2500
Best way to submit is on MyEnroller online application highlighted below.
Can also use the CSB Submission link: https://www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

After Submitting
Moving file from "Applications" folder to "Client" folder

Log client into Senior Agent Tools

Great western interview prep- say no to all health questions.
Interviewer will call from Iowa number 515 zip code

Medical Condition(s)	Medications(s) - including oxygen	Dosage	Duration (from/to)

GWIC® GREAT WESTERN INSURANCE COMPANY

Great Western Final Expense Insurance

SALES KIT BOOKLET

AGENT INSTRUCTIONS

Please complete the following:

- ☐ Application for Final Expense Insurance Policy
- ☐ Bank Draft Information
- ☐ Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: my.gwic.com/online

Mail
Great Western Insurance Company
P.O. Box 14410
Des Moines, IA 50306-3410

Fax
515-247-2500

If you have any questions, please call 866-252-5594.

GREAT WESTERN INSURANCE COMPANY

Agent Number: _____

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Application for Individual Life Insurance

A. Proposed Insured *(Full legal name)*

First Name	Middle Initial	Last Name

Street Address	City	State	Zip Code

Phone Number	Date of Birth (mm / dd / yyyy)	Social Security Number

Sex: ☐ Male ☐ Female	Email Address

B. Owner *(Complete only if other than proposed Insured)*

First Name	Middle Initial	Last Name

Street Address	City	State	Zip Code

Phone Number	Date of Birth (mm / dd / yyyy)	Social Security Number

Sex: ☐ Male ☐ Female	Email Address	Relationship to Insured

C. Health Questions

1) In the last two years, has the applicant been a patient in hospice, a hospital, or a nursing home for five or more days? ☐ Yes ☐ No

2) Is the applicant unable to independently perform routine activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair? ☐ Yes ☐ No

3) In the last two years, has the applicant been diagnosed with, been prescribed medication for or treated by a healthcare provider for any of the following diseases: Cancer (other than basal cell carcinoma), Tumor, Insulin-Dependent Diabetes, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Acquired Immune Deficiency Syndrome-Related Complex (ARC), or any Disorder of the Blood, Kidney, Lung, Brain, Heart, Circulatory System, or Liver? *For Prescriptions: Please do not mark "Yes" if the prescription(s) is a maintenance medication and has remained the same (or the generic equivalent) at the same or at a decreased dosage for the past two years. For Treatment: Please do not mark "Yes" if your visit(s) with your healthcare provider in the last two years was a routine review of your maintenance medication and no additional treatment was given or diagnosis was made during your visit(s).* ☐ Yes ☐ No

If all of the health questions are answered "NO," then the proposed Insured is eligible for a Level Death Benefit. If one or more of the health questions are answered "YES" or are not answered, then the Policy will be issued with a Graded Death Benefit.

Primary Care Physician *(Required for Level Death Benefit)*	Phone Number

D. Policy Information

Face Amount: $	Ultimate Death Benefit: $ *For Level Death Benefit, multiply Face Amount by 125%*

Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	Base Premium Amount: $
☐ Dependent Child / Grandchild Rider *(complete separate application)* *$5,000 Face Amount on base Policy is required*	Rider Premium Amount: $
	Total Premium Amount: $

Spousal Bonus Rider – Full Name and Date of Birth:
$10,000 Face Amount on each Policy is required

Proposed Insured's Last Name: _____

E. Beneficiary Information *(Use additional form for more beneficiaries)*

Primary *(Full legal name)*		Relationship	
Street Address	City	State	Zip Code
Contingent *(Full legal name)*		Relationship	
Street Address	City	State	Zip Code

F. Agreement

By signing below, I agree: (1) To the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Insured must be alive and in the same health as described or there will be no insurance. (3) The full premium for the chosen mode must be paid by the time the Policy is delivered. By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that have been made to the Policy for which I am applying.

Insurable Interest: I certify compliance with all of the insurable interest laws in force in the state in which this Policy will be issued.

Authorization: I authorize any healthcare provider, medical facility, pharmacy benefit manager or other pharmacy related services organization, health plan, insurance company, MIB, Inc., claims administrator, government agency, or other person or firm, to disclose to Great Western Insurance Company (GWIC) or its authorized representative, any records or information it needs about the Insured's health, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to the Insured. I understand that such information will be used by GWIC for the purpose of evaluating my application for insurance. A copy of this approval will be as effective as the original. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize GWIC, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that I or any authorized representative will receive a copy of this authorization upon request. This approval is valid for twenty-four (24) months from the date signed. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. This authorization may be revoked by me in writing, which I may do at any time by contacting GWIC.

I affirm that no illustration was used in the sale of this product.

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

G. Privacy Policy

I agree to receive electronically all initial and annual privacy policy notices associated with this insurance policy. Notices will be sent to the email address provided above. ☐ Yes ☐ No _____ Initial

H. Signature Section

Do you have any existing insurance policies or annuity contracts? ☐ Yes ☐ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? ☐ Yes ☐ No
If "Yes, complete required replacement form(s).

x _____ Signed on: _____ Signed at: _____
Proposed Insured's Signature (mm / dd / yyyy) (City, State)

x _____ Signed on: _____ Signed at: _____
Owner's Signature *(If other than Proposed Insured)* (mm / dd / yyyy) (City, State)

I. Agent Section

Does the applicant have any existing insurance policies or annuity contracts? ☐ Yes ☐ No

Will the insurance applied for replace or change any insurance or annuity that is now or has recently been in force? ☐ Yes ☐ No

_____ _____
Agent Full Name *(Please print)* Agent Number

x _____ _____
Agent's Signature Signed on (mm / dd / yyyy)

GWIC® GREAT WESTERN INSURANCE COMPANY

P.O. Box 14410 Des Moines, IA 50306-3410
Fax: 515-247-2500 • Phone: 1-800-733-5454
Email: FENEW@GWIC.COM • Website: www.gwic.com

Child/Grandchild Protection Plan

State_____ *(Print)* Agent Name_____ Agent Number_____ Date_____

Insured's Information

First Name	Middle Initial	Last Name	
Street Address	City	ST	Zip
Phone #	Date of Birth (mm/dd/yyy)	Social Security #	
Sex: ☐Male ☐Female	Email Address		

Child / Grandchild Protection Rider Information

Existing Policy #	Rider Premium $1.00 per month

Does the applicant have any existing policy or annuity? ☐YES ☐NO

Will the proposed insurance replace any existing policy or annuity? ☐YES ☐NO

If yes, please complete a replacement form

Conditions of Child / Grandchild Protection Plan

I apply for the Child / Grandchild Protection Plan and understand that only the Covered Child / Grandchild(ren) who are listed below and who meet the following conditions will be covered.

- The Covered Child / Grandchild is living with a parent, grandparent, or guardian at the time of death and has never married.
- The Covered Child / Grandchild is at least one year of age and has not attained the age of eighteen (18) years.
- The Covered Child / Grandchild dies while the Insured on the base Policy is alive.
- The coverage under the base Policy to which this Rider is attached is active and current in its premium payments.

Child/Grandchild's Full Name	Date of Birth	Child/Grandchild's Full Name	Date of Birth

Agreement

Agree by signing below, I agree that (1) to the best of my knowledge and belief, statements in this Application are complete and true. (2) When the Policy is delivered, the Applicant and listed child / grandchild(ren) must be alive. Also, the full premium must be paid by the time the Policy is delivered. (3) By keeping the Policy past the free look period, my written consent is hereby given to any change(s), correction(s), or addition(s) that GWIC may make to the Policy for which I am applying.

X _____ Signed on _____ Signed at _____
Insured's Signature (mm/dd/yyyy) (City, State)

X _____ **X** _____
Owner's Signature *(If other than the Proposed Insured)* Agent's Signature

For the Agent: Is replacement of insurance involved? ☐Yes ☐No

To the Applicant: You should hear from the Company within sixty days of the application date. If you don't, state the facts of your application in a letter to the Secretary of the Great Western Insurance Company at the address listed above.

GREAT WESTERN INSURANCE COMPANY

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Email: FENEW@GWIC.COM • Website: www.gwic.com

Life Replacement Advertising

AGENT'S STATEMENT

I,_____ have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

X _____
Agent Signature

_____
Agent Number

_____
Date

Complete and Send With Application

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Notice Regarding Replacement

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

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 maybe 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 or contract 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. Contract 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 response herein are, to the best of my knowledge, accurate:

X _____

Applicant’s Signature | Applicant’s Printed Name | Date

X _____

Agent’s Signature | Agent’s Printed Name | Date

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Information on the Accelerated Death Benefit Rider

INCLUSION OF RIDER
If you qualify for a Level Death Benefit policy, your policy will automatically include the Accelerated Death Benefit Rider at no additional charge. You qualify for the Level Death Benefit by answering "No" to the health questions on the application and providing your primary care physician's information.

DESCRIPTION OF RIDER
Great Western Insurance Company will pay an Accelerated Death Benefit to the Owner upon proof the insured has a Qualifying Medical Condition. Payment is subject to the terms and conditions of the Policy and this Rider while the Policy and this rider remain in force.

QUALIFYING MEDICAL CONDITION
Qualifying Medical Condition means either: 1.) Terminal Illness - You are terminally ill. You are expected to die within 12 months. Or 2.) Chronic Illness - You cannot perform two Activities of Daily Living for a period of at least 90 days. Or you have permanent severe cognitive impairment and similar forms of dementia requiring substantial supervision.

EFFECT OF RECEIPT OF BENEFITS
The application and receipt of an Accelerated Death Benefit will terminate your policy. You will not receive any additional death benefit on the death of the insured. The policy will not have any cash value after receipt of the Accelerated Death Benefit. You will not be required to pay additional premiums for the policy after receipt of the Accelerated Death Benefit. Any loan on the policy at the time of receipt of Accelerated Death Benefit will be paid off by the benefit before you receive the Accelerated Death Benefit and you will not be able to take future loans from the policy.

BENEFIT
The Accelerated Death Benefit paid to you may be reduced by an administrative charge and interest charges.

TAXES AND GOVERNMENT ASSISTANCE
This Accelerated Death Benefit may be taxable. We have not intended for this Accelerated Death Benefit to qualify for favorable tax treatment. Prior to electing to receive the Accelerated Death Benefit, you should seek assistance from a qualified tax adviser.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs, such as Medicaid. Prior to electing to receive the Accelerated Death Benefit, you should consult with the appropriate social services agency concerning how receipt of Accelerated Death Benefits may affect that eligibility.

USE OF PROCEEDS
This benefit will not restrict your use of proceeds. The benefits provided by this Accelerated Death Benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance.

ADDITIONAL INFORMATION
When you receive your policy, you will receive the Accelerated Death Benefit Rider form which will explain the benefits and conditions of this option fully.

There is no charge for this rider, and you may choose not to apply for Accelerated Death Benefits even if you have a Qualifying Medical Condition.

X _____	X _____	_____
Applicant's Signature	Agent's Signature	Date

BANK DRAFT INFORMATION

Complete this section only if you selected the automatic bank withdrawal payment option.

Ongoing Premium

Authorization to Bank or Other Financial Institution

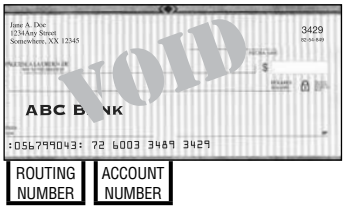
☐ Checking ☐ Savings Requested Withdrawal Date (1st - 28th only) _____

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Great Western Insurance Company (the "Company") for insurance premiums. I authorize the Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.