GROUP CONVERSION
APPLICATION INSTRUCTIONS

1. COMPUTATION SHEET:
   Premium rates are shown for the Protector Plan.
   The Protector plan provides for a level amount of insurance. Level premium payments are required for life.

2. GROUP CONVERSION REQUEST AND APPLICATION GP1217-D-2003:
   a. The Employer needs to complete the top of page one, fully answering all questions. The employer's authorized representative must also sign and date the top of the form.
   b. The Proposed Insured must fully complete the application portion pages, answering all questions.
   c. Page 4 is the signature area for the Proposed Insured and witness to sign and date.
   d. A check for the initial premium, based on the premium method that you selected, must be submitted with the application.
   e. DEADLINE: The application and first premium must be received at Lafayette Life's Home Office no later than 31 days following termination of your group insurance.

3. DISCLOSURE STATEMENT FORM DISC-WSI07-ABO:
   a. The Protector Plan contains an Accelerated Benefit Option. This Disclosure form explains the benefit.
   b. The Proposed Insured must sign page 2 of the form.
   c. Send the signed form (both pages) along with the application.
   d. Keep the second form for your records.

4. PREAUTHORIZED WITHDRAWAL FORM 1004:
   a. If you want future premium payments automatically deducted monthly from your checking account, complete this form. If you chose another method of payment, ignore this form.
   b. Fill in Name of Insured and Premium Amount.
   c. Your premium withdrawal will normally be on the same day as the policy issue day (32nd day following termination of your group insurance). If you want to choose another date, you may select a withdrawal date up to 12 days before or 12 days after the policy date.
   d. Signatures of the checking account holders must be completed at the bottom of the form.
   e. Attach a sample void check with this form and submit it along with the application.

If you have any questions, you may contact Group Customer Service at 1-800-952-8486 ext. 3711

THE LAFAYETTE LIFE INSURANCE COMPANY

Computation Sheet / Group Conversion Table

Annual Rates per Thousand for The Protector Plan (WSI-07)

Issue Age*	Male	Female	Issue Age*	Male	Female
25	16.53	14.05	50	36.57	26.93
26	16.93	14.42	51	37.96	27.91
27	17.41	14.77	52	39.34	29.14
28	17.92	15.17	53	40.86	30.48
29	18.47	15.58	54	42.50	31.82
30	18.92	15.91	55	44.10	34.56
31	19.29	16.15	56	46.06	36.34
32	19.93	16.40	57	48.22	38.24
33	20.68	16.90	58	50.58	40.14
34	21.57	17.51	59	53.35	42.16
35	22.70	18.36	60	56.43	44.10
36	23.34	18.97	61	59.92	46.05
37	24.09	19.58	62	63.72	48.02
38	24.84	20.20	63	67.63	50.10
39	25.60	20.81	64	71.46	52.39
40	26.35	21.54	65	75.00	55.00
41	27.12	22.27	66	77.88	57.70
42	27.99	22.88	67	80.56	60.70
43	28.76	23.50	68	83.32	64.00
44	29.51	23.99	69	86.48	67.40
45	30.26	24.48	70	90.32	71.00
46	31.66	25.09			
47	32.92	25.58			
48	34.05	25.82			
49	35.31	26.32			

*Issue age is your age as of the effective date which is 32 days after your last day worked.

You can calculate how much insurance will cost you by using the above table. Find your age and sex for the correct rate per thousand.

_____________ ÷ 1,000 =_______ X ____________ = ________+ $30.00 (processing fee) =____________
Amount of Insurance Rate per thousand Annual Premium

Annual Premium X .51 = Semi-Annual Premium
Annual Premium X .26 = Quarterly Premium
Annual Premium X .085 = Preauthorized Withdrawal Premium (PAW) **

Example: A 44 year old female is requesting a $50,000 life insurance policy
50,000 ÷ 1,000 = 50 X 23.99 = $1,199.50 + $30.00 = $1,229.50
Annual Premium $1,229.50, Semi-Annual Premium $627.04, Quarterly Premium $319.67, PAW $104.51.

**If you want to pay your premium on a monthly Pre-authorized Withdrawal basis, please follow instructions on Form 1004 found at the end of this application packet. You will need to sign and date the form and include a void check with it in order to have premium paid through Pre-Authorized Withdrawal (PAW).

GROUP CONVERSION REQUEST

THE LAFAYETTE LIFE INSURANCE COMPANY ("Lafayette Life")
1905 Teal Road, P.O. Box 7007 Telephone (800) 952-8486
Lafayette, Indiana 47903 Facsimiles (765) 477-3369

To be completed by Policyholder/Participating Employer:

Policy Number: ____________________ Certificate No.: ______________________

Date Insurance Effective with Lafayette Life:_________________ Amount of Basic Life Insurance: ____________________

Amount of Supplemental Life Insurance (if any):______________ Amount of Additional Life Insurance (if any):__________

Name of Applicant: ____

Date of Birth:______________________ Social Security Number: _________________ Date Last Worked: ____________

Is applicant a Dependent of an Employee/Member: ☐ Yes ☐ No

Termination Date (of Employee/Member):________________________

Reason for Termination: ☐ Discharged or Resigned ☐ Leave of Absence ☐ Layoff ☐ Retired
☐ Other:____

Is conversion requested due to termination of the group life insurance policy? ☐ Yes ☐ No

If "Yes," what was the effective date of termination of group life insurance policy with Lafayette Life: __________________

Did Applicant elect to continue any insurance under the Portability of Insurance Benefit provision?☐ Yes ☐ No

If "Yes," which coverages did Applicant elect to continue and in what amounts (check all applicable):

☐ Basic Life Insurance $ ___________ ☐ Supplemental Life Insurance (if any) $ _________________________________

☐ Additional Life Insurance (if any) $ ________________ ☐ Dependent Basic Life Insurance $____________________

Name of Policyholder/Participating Employer ____

Authorized Representative ____
(Please Print)

Signature of Authorized Representative ____

Title _____________________________________ Date of this notice ____

APPLICATION FOR CONVERSION OF BASIC LIFE INSURANCE

To be completed by Employee/Member or Spouse
Pursuant to the terms and conditions of the Conversion Privilege contained in this Policy, I hereby apply for an individual policy of life insurance, without supplemental benefits as follows: (**NOTE: This application & first premium must be received in our Home Office not later than 31 calendar days of termination of our Basic Life Insurance.)**
Full Name of Proposed Insured ____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Social Security No: _________________ State of Birth: _______Date of Birth: _________ Age:_______________
Plan:____

Amount of Insurance: ____
(May not exceed amount eligible for conversion under this Policy's Conversion Privilege)

Premium Payments: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Preauthorized Withdrawal
Note: If Preauthorized Withdrawal (PAW) is premium payment choice, please attach copy of voided check and complete 1004 form.

Address for Premium Notices: ____
____

Automatic Premium Loan Provision is contained in all policies if state law permits unless marked "NO". NO ☐

Were you covered as (check one) ☐ Employee/Member or ☐ Dependent under this Policy? If you checked "Dependent", please provide the full name, date of birth and social security number of Employee/Member of whom you were dependent.

Full Name of Employee/Member: ____

Employee/Member Date of Birth: ________________ Employee/Member Soc. Sec. No.: ____________________

Primary Beneficiary Information (Print Full Given Name):

Name of Primary Beneficiary:	Age	Relationship	Social Security Number	Date of Birth
Address of Primary Beneficiary:				

Contingent Beneficiary Information (Print Full Given Name):

Name of Contingent Beneficiary:	Age	Relationship	Social Security Number	Date of Birth
Address of Contingent Beneficiary:				

Did you become eligible for coverage under another group life insurance policy within 31 days of the date your coverage under this Group Policy terminated? If yes, please provide amount of coverage for which you became eligible:______________________________

Illustration Certification – The Protector Plan is a non-illustrated policy.
If any other plan is chosen, no illustration was used in the application process.
The undersigned agent certifies that an illustration was not used in connection with the application for insurance to The Lafayette Life Insurance Company submitted by the applicant. The undersigned applicant acknowledges that no illustration was used in connection with the application for insurance. The applicant further acknowledges the understanding that an illustration, conforming to the policy as issued, will be provided no later than the time of delivery of the policy.

"Group Policy" means the group life insurance policy issued by The Lafayette Life Insurance Company to the Policyholder/Participating Employer, as applicable, of the person named as Employee/Member or under which the Policyholder/Participating Employer a person was an eligible unit of the Policyholder/Participating Employer.

"Dependent" means a person who is the lawfully married spouse of the Employee/Member or any unmarried child of the Employee/Member who was defined as a Dependent in the Group Policy and who was eligible for conversion of insurance under the Group Policy Conversion Privilege.

It is understood and agreed as follows:
A. All statements made in the application are representations and not warranties and are true, complete and correct and shall form the basis for all insurance, which may be issued under this application.

B. The insurance applied for shall not take effect unless and until this application and the full first premium are received at the Home Office of The Lafayette Life Insurance Company on or before thirty-one (31) days following the date the undersigned Proposed Insured becomes eligible for conversion under the Group Policy.

C. If conversion has been exercised by a Dependent, the personal signing as Proposed Insured certifies that the Proposed Insured was a covered Dependent under the Group Policy at the time of the named Employee's/Member's coverage terminated.

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief.

REQUIRED FRAUD WARNINGS:

ARKANSAS, LOUISIANA OR NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE OR IDAHO: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: Warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

INDIANA: A person who knowingly, and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE OR TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who submits an application or files a claim with intent to defraud or help commits a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to civil and criminal penalties.

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

OKLAHOMA: Warning: any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Date: ____

Agent Name: ______________________________ Agent Signature: ____
(Please Print)

Signature of Proposed Insured: ____

Signed at: ____
City & State

Witnessed; ____ Premium enclosed $ ________________________________

Please mail to: The Lafayette Life Insurance Company
1905 Teal Road, P.O. Box 7007
Lafayette, Indiana 47903

Please note: If computation sheet is not enclosed, please visit our web site at *www.llic.com*

DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT OPTION (Form WSI-07)

Summary - This policy contains an accelerated benefit option. You may elect to have policy benefits accelerated in the event one of the following qualifying events were to occur to the Insured: a qualifying confinement to a nursing home; or a qualifying terminal illness. If you receive benefits under this provision, your policy will terminate. The benefit under this provision is less than the death benefit of the policy. There is no premium for the accelerated benefit option.

This policy will normally pay a benefit to the policy beneficiary *after* the Insured dies. It is called a "death" benefit.

Accelerated Benefit Option

The accelerated benefit option in this policy provides an alternative way in which a benefit can be paid to you *before* the Insured dies. Because it is paid earlier than normal, it is called an "accelerated" benefit.

There are two qualifying events for which you may elect to receive an accelerated benefit. They are:

- The Insured becomes confined to an eligible nursing home and is expected to stay there until death due to a specific diagnosed accident or sickness condition; or
- The Insured develops a terminal illness which a physician certifies is expected to result in death in 12 months or less.

You are not eligible to elect an accelerated benefit if:

- The qualifying event results from:
  a) an illness the Insured has during the first 30 days after the Date of Issue of the policy; or
  b) an intentional self-inflicted injury, or attempted suicide; or
- You or the Insured are required to use this Accelerated Benefit Option:
  a) by law to meet the claims of creditors, whether in bankruptcy or otherwise; or
  b) by a government agency in order to apply it to obtain, or keep, a government benefit or entitlement.

Your right to an accelerated benefit is also subject to the following conditions:

- The policy must be inforce other than as reduced paid-up insurance or extended term insurance; and
- The policy must not be assigned, other than to us as security for a policy loan.

Accelerated Benefit Amount

The amount of the accelerated benefit will be less than the death benefit that would normally have been paid to the policy beneficiary. Your accelerated benefit will be the death benefit at the time you request the accelerated benefit discounted for one year at the policy loan interest rate in effect at the time you request the accelerated benefit.

For example, if you assume the death benefit is $10,000 and the loan interest rate in effect is 7.00% at the time you request an accelerated benefit, the accelerated benefit would be $10,000 divided by 1.0700 (the sum of one and the loan rate), or $9,345.80. The hypothetical assumed amounts and rates in the example are not guaranteed and are used for example purposes only. The loan interest rate is subject to change.

This means that if you elect to receive the accelerated benefit, it is less than the death benefit that would have been paid to the policy beneficiary.

Effect on the Policy

If you elect to have policy benefits accelerated, the policy will terminate. The policy will no longer exist. There will no longer be any premiums, any cash value, or any policy loan. No death benefit will be paid to the policy beneficiary.

one copy – Applicant
one copy - Company

Medicaid and Tax Consequences

Receipt of accelerated benefit payments may adversely affect eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor.

Premium for Accelerated Benefit

There is no additional premium or administrative expense charge for the accelerated benefit option. The cost for your electing to have policy benefits accelerated will be the difference between the death benefit and the accelerated benefit.

The accelerated benefit option is not long-term care insurance.

This is a brief description of the accelerated benefit option. The benefit is subject to the terms and conditions of the policy, form WSI-07.

For additional information contact your agent or the company at 1-800-243-6631.

______________________	______________________	______________
Applicant's Signature	Agent's Signature	Date

THE LAFAYETTE LIFE INSURANCE COMPANY, 1905 Teal Road, P.O. Box 7007, Lafayette, IN 47903
1-800-443-8793

one copy – Applicant
one copy - Company

DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT OPTION (Form WSI-07)

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one copy – Applicant
one copy - Company

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The accelerated benefit option is not long-term care insurance.

This is a brief description of the accelerated benefit option. The benefit is subject to the terms and conditions of the policy, form WSI-07.

For additional information contact your agent or the company at 1-800-243-6631.

Applicant's Signature	Agent's Signature	Date

THE LAFAYETTE LIFE INSURANCE COMPANY, 1905 Teal Road, P.O. Box 7007, Lafayette, IN 47903
1-800-443-8793

one copy – Applicant
one copy - Company

PREAUTHORIZED WITHDRAWAL

I authorize The Lafayette Life Insurance Company to initiate electronic fund transfer debits ("EFT debits") or to draw checks or drafts each month on the account at the bank or credit union named on the sample void check attached in the amount indicated to pay the premium, repay a loan or carry out the other purpose stated herein in connection with the below numbered policy or policies issued by the respective company. The issuing company is authorized to initiate EFT debits or to draw such checks or drafts in the necessary amount as provided in the policy, including the authority to increase the amount of the EFT debit or check if the policy provides for an increase in premium in the future.

A SAMPLE VOID CHECK OR SAMPLE VOID DRAFT MUST ACCOMPANY THIS FORM

(Please no deposit slips)

I hereby request and authorize my bank and/or credit union to honor and charge to my account EFT debits and checks or drafts drawn on my account for the purposes stated above and made payable to The Lafayette Life Insurance Company for banking purposes. The signature on such checks or drafts may be either typed or printed.

This authorization does not modify or change the provisions of the policy or policies to which this authorization applies except any right of the owner(s) to receive a notice of payment due which is expressly waived. Neither the authorization or its use shall modify the provisions of the policy or policies with respect to nonpayment of any premium or days of grace.

The privilege of making payments by Preauthorized Withdrawal may be revoked if any EFT debit, check, or draft is not paid upon presentation.

If the authorization is later cancelled, payment must be paid quarterly, semiannually, or annually. If more than one policy is to be paid under this authorization, the Company may combine the monthly payments in one EFT debit, check, or draft.

Policy or Application Number	Name of Insured	Premium Amount $10.00 Minimum	Other	Type of Account
				☐ Checking ☐ Savings

DATE OF WITHDRAWAL _______________

NOTE TO AGENT: UNLESS REQUESTED OTHERWISE, FOR NEWLY ISSUED POLICIES THE WITHDRAWAL DATE 1. WILL BE THE SAME DAY AS THE POLICY ISSUE DAY (FOR A NEW MONTHLY WITHDRAWAL) OR 2. ADDED TO AN EXISTING MONTHLY WITHDRAWAL IF REQUESTED (UNIVERSAL LIFE POLICIES WITHOUT A ROLLOVER PAYMENT ***CANNOT*** BE DRAWN AFTER THE POLICY ISSUE DAY).

I request the company to withdraw the initial payment(s)* ________________ (initials of depositor)

*Insurance is not effective until initial payment is honored by depositors bank

Bank ______ Please PRINT Name of Depositor's Account ______ Depositor Account Number ______

Bank Address ______ City / State / Zip ______

Signature of Depositor ______ and Signature of Joint Depositor (Joint Depositor Must Sign) ______ Signature of Policyowner (If Other Than Depositor) ______ Date ______

Form 1004 4/04 W

1905 Teal Road • P.O. Box 7007 • Lafayette Indiana 47903-7007
Individual Product Operations: 1-800-243-6631 ext 3751 • Fax: 1-765-477-3298