**Instructions: 1. Please do not separate pages. 2. Complete all required sections in ink and return to the Home Office.**

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# Application For Life Insurance

## Grange Life Insurance Company

650 South Front Street : P.O. Box 1218
Columbus, OH 43216-1218
614-445-2900

L-3-22Q (7-2002)

**This Notice Must Be Given To Proposed Insured**

**NOTICE OF INFORMATION PRACTICES**
**(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)**

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you.

Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the MIB, Inc. (Medical Information Bureau), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information to other life companies to whom you apply for life or health insurance, or to whom a claim is submitted. MIB information will only be released to MIB, Inc. members.

In addition, we may get an Investigative Consumer Report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report.

Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

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**Grange Life Insurance Company**
**Columbus, Ohio 43206**

**(Do not detach unless the full First Premium is paid with Application.)**

**CONDITIONAL COVERAGE RECEIPT**

COVERAGE PROVIDED BY THIS RECEIPT SUBJECT TO ALL EXCLUSIONS AND PROVISIONS OF THE POLICY APPLIED FOR. THIS RECEIPT PROVIDES A LIMITED AMOUNT OF INSURANCE, FOR A LIMITED PERIOD OF TIME, AND THEN ONLY IF ALL THE TERMS AND CONDITIONS ARE MET. NO AGENT CAN ALTER OR WAIVE ANY OF THE PROVISIONS OF THIS RECEIPT. IT IS VOID IF ALTERED OR TRANSFERRED.

RECEIVED: ☐ Cash or Check in the amount of $ __________ from __________
as conditional payment on the lives of the Proposed Insured(s). __________
An application for insurance bearing the same number and date as this Receipt is this day made to Grange Life Insurance Company. This conditional payment is subject to the conditions set out below. This Receipt is void and there is no insurance if such payment is by check or draft and it is not honored by the bank when presented for payment. If the insurance applied for does not become effective, any money or authorization received will be returned to the Owner. All premium checks must be payable to GRANGE LIFE INSURANCE COMPANY.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY - Unless each and every condition below has been fulfilled exactly, the insurance will become effective only as described in the Declarations section of the application.

EFFECTIVE DATE OF COVERAGE - Insurance issued based on the application will take effect, subject to the Conditions below, on the latest of: (1) the date of the application; or (2) the date requested in the application; or (3) the date of the last of any medical examinations or tests required under Grange's rules and practices.

CONDITIONAL COVERAGE - Insurance issued based on the application will take effect only if these conditions are met: (1) on the Effective Date the Proposed Insured(s) is (are) qualified exactly as applied for under Grange's rules and practices for the plan, amount and premium rate applied for; and (2) the amount paid with the application is equal to the full first premium for the insurance; and (3) the maximum Amount Of Coverage specified below is not exceeded.

AMOUNT OF COVERAGE - $250,000 MAXIMUM INSURANCE - In no event will the amount of life insurance which may become effective under this Receipt, when added to the amount of insurance in force or applied for with Grange, exceed $250,000. If the application is for insurance in excess of this amount, any excess insurance will become effective only as described in the Declarations section of this application.

TERMINATION AND REFUND OF PREMIUM - If the application to which this Receipt was attached is not approved as applied for by Grange within ninety days from its date, this Receipt shall be void. Grange's only liability in such event will be to return any money received.

**THIS RECEIPT IS NOT VALID UNLESS SIGNED BY A LICENSED AGENT OF GRANGE.**

**Agent's Signature** ______________________________ **Date** ______________

**PART 1 - Application For Life Insurance**

**Please Print Using Dark Ink**

**Grange Life Insurance Company**
**650 South Front Street, PO Box 1218**
**Columbus, Ohio 43216-1218**

**Cash With Application** $

**Section I**

**Proposed Insured # 1**

| Name (Last First Middle) | Date of Birth M D Y | State of Birth | Social Security No. |
|---|---|---|---|
| | | | |

| Maiden Name | Home Address |
|---|---|

| County | City | State | Zip | How Long? |
|---|---|---|---|---|

| Phone # (Home) | Sex | Marital Status | Occupation | Employer |
|---|---|---|---|---|

Is residence within a municipality? ☐ Yes ☐ No If "Yes," name ______ Drivers License #: ______

| Business Address | City | State | Zip | How Long? |
|---|---|---|---|---|

**Section II**

**Proposed Insured # 2**

| Name (Last First Middle) | Date of Birth M D Y | State of Birth | Social Security No. |
|---|---|---|---|
| | | | |

| Maiden Name | Home Address |
|---|---|

| County | City | State | Zip | How Long? |
|---|---|---|---|---|

| Phone # (Home) | Sex | Marital Status | Occupation | Employer |
|---|---|---|---|---|

Is residence within a municipality? ☐ Yes ☐ No If "Yes," name ______ Drivers License #: ______

| Business Address | City | State | Zip | How Long? |
|---|---|---|---|---|

**Section II-A Dependent Children (If Proposed for Coverage)**

| Name (Last First Middle) | Sex | Date of Birth M | D | Y | Age | State of Birth | Height | Weight |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | ft. in. | lbs. |
| | | | | | | | ft. in. | lbs. |
| | | | | | | | ft. in. | lbs. |
| | | | | | | | ft. in. | lbs. |

**Section III**

**Applicant/ Owner/ Payor**

| Name of Applicant/Owner (if other than Proposed Insured # 1) (Applicant must sign Page 4) | Relationship | Social Security No. or Taxpayer I.D. No. |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|

If Proposed Insured is a minor, ownership will pass to Proposed Insured at age ______ . (If no designation is made, ownership will pass to Proposed Insured at age 21).

All notices and reports will be sent to the Owner unless otherwise specified in Special Requests section, Page 2.

Is residence within a municipality? ☐ Yes ☐ No If "Yes," name ______

**Section IV**

**Policy**

**(Proposed Insured # 1)**
Basic Plan of Insurance

| | Face Amount |
|---|---|
| ☐ Universal Life | $ |
| ☐ Whole Life | $ |
| ☐ Annual Renewable Term | $ |
| ☐ Level Term ____ Yrs. | $ |
| ☐ Other ______ | $ |

**(Proposed Insured # 1)**
Riders Available

| | Amount |
|---|---|
| ☐ Primary Insured Rider | $ |
| ☐ Accidental Death | $ |
| ☐ Children's | $ |
| ☐ Guaranteed Insurability Option | $ |
| ☐ Other ______ | $ |
| ☐ Waiver of Premium | |
| ☐ Long Term Care (UL Only) | |

**(Proposed Insured # 2)**
Coverage Available

| | Amount |
|---|---|
| ☐ **Spouse** | $ |
| ☐ **Other Insured** | $ |

Nonforfeiture Option: (Unless stated will default to Extended Term Insurance for Regular Premium Class or Paid-up Insurance for Special Premium Class)

______

**Universal Life Only**
☐ Level Death Benefit (Option A)
☐ Increasing Death Benefit (Option B)

| | Amount |
|---|---|
| Planned Annual Premium | $ |
| Planned Rollover | $ |

**Automatic Premium Loan**
(Whole Life Only) ☐ Yes ☐ No

Part I - (Continued)

**Section V**

**Premium**

Premium Frequency: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ PAC ☐ List Bill

Requested Policy Date:

| M | D | Y |
|---|---|---|
| | | |

Send premium notices to: ☐ Home ☐ Business (Give any special mailing address in Special Requests section, Page 2.)

**Section VI**

**Beneficiary For Proposed Insured # 1**

| PRIMARY BENEFICIARY: Full Name | Percent | Relationship |
|---|---|---|
| | % | |
| | % | |
| **CONTINGENT BENEFICIARY: Full Name** | **Percent** | **Relationship** |
| | % | |
| | % | |

**If more than one, then equally to the survivors unless otherwise stated.**

**Section VI-A**

**Beneficiary For Proposed Insured # 2**

| PRIMARY BENEFICIARY: Full Name | Percent | Relationship |
|---|---|---|
| | % | |
| | % | |
| **CONTINGENT BENEFICIARY: Full Name** | **Percent** | **Relationship** |
| | % | |
| | % | |

**If more than one, then equally to the survivors unless otherwise stated.**

**Section VII**

**Existing and Pending Insurance**

**Life Insurance In Force and Pending on All Proposed Insureds, Including Business Insurance: (If none, insert "None.")**

| Name of Insured | Company | Type of Coverage | Life Amount | Accidental Death | Year Issued |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Regarding all Proposed Insureds:** (If any "Yes," give name, date and details in Remarks below.) **Yes** **No**

(a) Has any life or health insurance been rated, or modified in any way? . . . . . . . . . . . . . . . . . . . . . . . . ☐ ☐

(b) Is the policy applied for to replace any existing insurance or annuity in this or any other company? . . . . . . . . ☐ ☐
(If "Yes," forward Replacement Form.)

(c) Has any life insurance lapsed, been surrendered or otherwise terminated in the last 24 months? . . . . . . . . . . ☐ ☐

**Section VIII**

**Special Activities**

**Has any Proposed Insured:** **Yes** **No**

(a) Flown as a Student, Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? (If "Yes," complete Aviation Questionnaire, Page 7.) . . . . . . . . . . . . . . . . . . . . . ☐ ☐

(b) Engaged in any form of racing, sky diving, underwater diving, or other hazardous activity in the past two years? . ☐ ☐
(If "Yes," complete Avocation Questionnaire, Page 8.)

**Section IX**

**Tobacco Usage**

**Has any Proposed Insured:** (If any "Yes," give name, date and details in Remarks below.) **Yes** **No**

(a) Used tobacco in any form within the past 48 months? Insured # 1 . . . . . . . . . . . . . . . . . . . . . . . . ☐ ☐
Insured # 2 . . . . . . . . . . . . . . . . . . . . . . . . ☐ ☐

If "Yes", give month & year last used. Insured # 1 ________ Month ________ Year
Insured # 2 ________ Month ________ Year

(b) If "Yes" what? Insured # 1 ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing ☐ Snuff
Insured # 2 ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing ☐ Snuff

**Section X**

**Other**

**Has any Proposed Insured: (If any "Yes," give name, date and details in Remarks below.)** **Yes** **No**

(a) Had driver's license restricted or revoked, or been cited for more than 3 moving violations within last 3 years? . . ☐ ☐

(b) Been arrested for a felony? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ ☐

(c) Do you contemplate travel or residence outside the United States and Canada in next 2 years? . . . . . . . . . . . ☐ ☐

**Remarks:** ____________________________________________
____________________________________________

**Special Requests:** ____________________________________________

## PART 1A - NON-MEDICAL SECTION

1. (a) Proposed Insured # 1: Height ft. in. | Weight lbs. | Weight change in past year: ☐ Gain ☐ Loss ☐ None ______ lbs.

   (b) Do you have a personal doctor? ☐ Yes ☐ No (If "Yes", last date consulted.) M D Y Reason: ______

   Name ______

   Address ______ City State Zip Code Telephone Number: ( )

2. (a) Proposed Insured # 2: (for Joint Insurance): Height ft. in. | Weight lbs. | Weight change in past year: ☐ Gain ☐ Loss ☐ None ______ lbs.

   (b) Do you have a personal doctor? ☐ Yes ☐ No (If "Yes", last date consulted.) M D Y Reason: ______

   Name ______

   Address ______ City State Zip Code Telephone Number: ( )

| | Each person to be insured | | | | | |
|---|---|---|---|---|---|---|
| | Prop. Ins. # 1 | | Prop. Ins. # 2 | | Children | |
| **3.** To the best of your knowledge have you or has any other Proposed Insured had or been told by a doctor in the past ten years that he or she had: (Circle conditions to which "Yes" answer applies and give details below.) | Yes | No | Yes | No | Yes | No |
| (a) Seizures, paralysis, mental or nervous disorder? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart, or circulatory system? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (c) Asthma, emphysema, bronchitis, tuberculosis, or chronic respiratory disease? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (d) Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastro-intestinal disorder? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (e) Complicated pregnancy, hysterectomy, disorder of breast or female organs? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (f) Disease of kidney, bladder, prostate, or sugar or protein in urine? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (g) Loss of vision, amputation, deformity, arthritis or any disorder of muscles, bones or joints? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (h) Cancer, tumor, diabetes or glandular disorder? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Yes | No | Yes | No | Yes | No |
| **4.** Have you been medically diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome ("AIDS") or AIDS Related Complex ("ARC")? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **5.** Have you ever tested positive for HIV? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **6.** To the best of your knowledge have you or has any other Proposed Insured: (Circle conditions to which "Yes" answer applies and give details below.) | Yes | No | Yes | No | Yes | No |
| (a) Other than above, had examination, treatment or consultation with a doctor, or been hospital confined during the past 5 years? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (b) Been on, or are now on, any medication or prescribed diet? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (c) Been treated for drug addiction, alcoholism or been a member of AA? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (d) Ever received disability benefits? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (e) Been advised to have any diagnostic test, hospitalization or surgery which has not been completed? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| (f) Had a parent, brother or sister who had cancer, diabetes, heart disease, or who committed suicide? (Please show age at onset and/or date of death.) ______ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Person's Name | Question Number | Details or Reason | Date | Name and Address of Attending Doctor and Hospital |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## HOME OFFICE ENDORSEMENTS

Not to be used where prohibited by Statute or Insurance Department ruling.
Not applicable in any state where Written Consent is required by law.

**Pre-Authorized Check Authorization:**

ATTACH CHECK HERE

**If P.A.C. (Pre-Authorized Check) withdrawals are requested, please complete the following information:**
**An amount equaling at least two months withdrawals <u>must be submitted</u> with this application to begin a P.A.C. account.**

I hereby authorize my bank to make payments to my insurance policy on a monthly basis from my checking account:

☐ Yes ☐ No Bank Name: ______________________________ Checking Account Number: ________________________

**Please Note - The initial bank draft may be in the amount of two monthly withdrawals to meet the minimum contribution requirements when insufficient monies accompany this application. Subsequent withdrawals will occur on the same day of each month as your contract date.**

>>>>> **PLEASE ATTACH VOIDED CHECK** (Please do not attach Deposit Slips) >>>>>

P.A.C. drafts can be discontinued by the policyowner at anytime upon written request to the **Grange Life Home Office.**

## DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

(1) All such statements and answers shall be the basis for and a part of any policy issued on this application.

(2) No agent or medical examiner can accept risks or make or change contracts or waive Grange's rights or requirements.

**(3) No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full premium is paid. However, If the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.**

(4) Acceptance of a policy by the Owner shall constitute ratification of any changes made by Grange under "Home Office Endorsements."

*Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information may be subjected to criminal penalties and the denial of coverage for claims made under the policy of insurance.*

**WE ARE REQUIRED BY LAW TO GIVE YOU THE FOLLOWING NOTICE:**

**Ohio and Tennessee -** 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.

**Kentucky -** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**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.

Dated ______________________________ (X) ______________________________
Signature of Proposed Insured # 1

Signed At ______________________________ (X) ______________________________
City and State — Signature of Proposed Insured # 2

______________________________ (X) ______________________________
Witnessed by Agent — Signature of Applicant/Owner
if Other than Proposed Insured # 1 or # 2
(If a corporation, state corporation name)

By ______________________________
Signature of Corporate Officer

**Grange Life Insurance Company**
**650 South Front Street, PO Box 1218**
**Columbus, Ohio 43216-1218**

## Authorization to Obtain and Disclose Information

I authorize Grange Life Insurance Company or its reinsurer(s) to obtain medical and other information on me or my minor children. This includes information about drugs and alcohol and about diagnosis, treatment and prognosis of any physical or mental condition, as well as any other non-medical information.

This information can be released by doctors including medical practitioners and pharmacists. It can also be released by any hospital, clinic or other medical or medically related facility, including facilities run by the Veteran's Administration. Information can also be released by insurers, reinsurers, the Medical Information Bureau (MIB), employers and consumer reporting agencies.

I also authorize all the above sources (except the MIB) to give such records or information to any consumer reporting agencies employed by Grange to collect and transmit such information.

I acknowledge that the information obtained by this authorization will be used by Grange to determine eligibility for insurance applied for, and may be used to determine eligibility for benefits under an existing policy. Any information obtained will only be released by Grange to reinsurers, the MIB, or other persons or organizations performing business or legal services in connection with my application or a claim. MIB information will only be released to MIB, Inc. members. The information may also be released if Grange is required to do so by law, or if I authorize its release.

This authorization shall be valid of 30 months from the date shown below. I may obtain a copy of this if I ask for it. A photographic copy shall be as valid as the original.

I authorize Grange Life Insurance to obtain an investigative consumer report on me. In connection with any investigative consumer report,

I/We ☐ do ☐ do not request a personal interview.

I have received a copy of the Notice of Information Practices.

Date: ______________________________

(X) ______________________________
Signature of Proposed Insured # 1

(X) ______________________________
Signature of Proposed Insured # 2

(X) ______________________________
Signature of Parent or Guardian,
if minor child(ren) proposed for insurance

**THIS APPLICATION MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED**

## AGENT'S REPORT

1. How long have you known Proposed Insureds? ______
2. Did you personally interview Proposed Insured and complete application in his or her presence? ☐ Yes ☐ No
3. To your knowledge, has any Proposed Insured smoked cigarettes within the past year? ☐ Yes ☐ No
4. Have you issued the "Notice of Information Practices"? ☐ Yes ☐ No
5. Will the policy applied for replace any existing insurance or annuity? ☐ Yes ☐ No
6. If policy applied for is term insurance, do you have knowledge that:
   - (a) There has been a replacement in the last 36 months? ☐ Yes ☐ No
   - (b) There have been more than two replacements in the last 60 months? ☐ Yes ☐ No
7. If Proposed Insured is a juvenile (ages 0 through 15):
   - (a) Did you personally see child? ☐ Yes ☐ No
   - (b) Does child live with parents? ☐ Yes ☐ No
     If "No," explain.) ______
   - (c) Life Insurance in force on Payor's life. $ ______
   - (d) Life Insurance applied for or in force on brothers and sisters. ______
8. Applicant's estimated annual income? $______
9. Is residence within a municipality? ☐ Yes ☐ No
10. For telephone interview, indicate the most convenient time to call. ______
11. Examination Arrangement Made. ______ Exam ______ EKG ______ Blood Chemistry
12. What other Grange Insurance does the Proposed Insured carry? ☐ Auto ☐ Fire or Homeowners ☐ Other Casualty ☐ Health ☐ None

I hereby certify that I know nothing affecting the insurability of any Proposed Insured which is not fully set forth in these papers.

Signed at ______________________ Date ______________
City and State

______________________ Signature of Licensed Agent

______________________ Agency Name and No.

**Remarks:**

Grange Life Insurance Company
650 South Front Street, PO Box 1218
Columbus, Ohio 43216-1218

**Aviation Questionnaire**

Name of Proposed Insured: ____________ Date of Birth: M ___ D ___ Y ___

**Section I — Hours Flown**

**For Pilots, Students and Crew Members:**

Total of Solo Hours Flown As Pilot or Crew Member: ______ Total Hours Flown In Past 12 Months: ______ Estimated Hours Flying In Next 12 Months: ______

**Section II — Pilot Certificate**

**Pilot Certificate currently held:** ☐ Private ☐ Student ☐ Airline Transport Rating (ATR) ☐ Instrument Flight Rating (IFR) ☐ Commercial ☐ Flight Instructor

Have you ever been grounded or had your license revoked? ☐ Yes ☐ No (If "Yes," give details in Remarks below.)

**Section III — Type Flying**

**Type of Flying:**
- ☐ Pleasure
- ☐ Personal Business
- ☐ Crop Dusting
- ☐ Employer Aircraft or Employee Transportation
- ☐ Freight Carrying or Passenger Service
- ☐ Instructor
- ☐ Other (Give details in Remarks below.)

**Section IV — Medical Certificate**

(a) Medical Certificate currently held: ☐ class III ☐ class II ☐ class I

(b) Date of last renewal: M ___ D ___ Y ___

| | Yes | No |
|---|---|---|
| (c) Was it denied by the Aviation Medical Examiner but eventually issued? | ☐ | ☐ |
| (d) Was it necessary to appeal before Certificate was eventually issued? | ☐ | ☐ |
| (e) Was Medical Certificate granted subject to limitation(s) or physical waiver(s)? | ☐ | ☐ |

(If any of the above questions are answered "Yes", please give details in Remarks below.)

**Section V — Military Flying**

(a) Military Branch or Organization ______

(b) Type Aircraft ______ Date of Last Flight M ___ D ___ Y ___

(c) If not pilot, specify capacity in which you fly ______

**Section VI — Other Flying**

**Other Type of Flying:**

| | Yes | No |
|---|---|---|
| (a) Have you ever flown or do you intend to fly: Ultralight, Biplane, Prototype, experimental or personally built or assembled aircraft? (If "Yes," complete Avocation Questionnaire, Page 8.) | ☐ | ☐ |
| (b) Have you within the past 12 months, or do you contemplate flying in the Civil Air Patrol? | ☐ | ☐ |
| (c) Do you contemplate a change from your present flying to commercial or military flying? (If "Yes," give details in Remarks below.) | ☐ | ☐ |

**Section VII — Aviation Rates**

Should you not qualify for full coverage at standard rates, do you desire:

| | Yes | No |
|---|---|---|
| (a) Full coverage with extra premium, if available? | ☐ | ☐ |
| (b) Restricted aviation coverage without extra premium, if available? | ☐ | ☐ |

**Remarks:**

**The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.**

Signed at ______________________ (X) ______________________
City and State — Signature of Proposed Insured

Date ______________________

Grange Life Insurance Company
650 South Front Street, PO Box 1218
Columbus, Ohio 43216-1218

**Hazardous Activities Questionnaire**

Name of Proposed Insured: ______ Date of Birth: M ___ D ___ Y ___

**Section I**

**Racing Sports**

Racing, Auto, Motorcycle,Snowmobile, Motorboat:

Type: ☐ Midget ☐ Stock ☐ Hotrod ☐ Drag ☐ Sportscar ☐ Snowmobile ☐ Cycle ☐ Boat ☐ Other ______

Vehicle or Boat: Make ______ Model ______ Class ______ Category ______

Displacement . . . . . ______ Horsepower ______

Timing: ☐ Vehicle vs. Vehicle ☐ Vehicle vs. Clock ☐ Maximum Speed Attained ______ mph

Location: ☐ Oval Track ☐ Closed Circuit ☐ Drag Strip ☐ Hill Climb ☐ Other ______

Have you ever had a racing accident? ☐ Yes ☐ No (If "Yes," explain details in Remarks below.)

Racing organizations affiliated with ______

Races supervised by ______

Frequency (Number of Races) . . . . . . Last 12 Months ______ 1 to 2 Years Ago ______ Estimate Next 12 Months ______

**Section II**

**Underwater Sports**

Type: ☐ Scuba ☐ Skin ☐ Snorkel Purpose: ☐ Recreation ☐ Rescue ☐ Salvage

Locations: ☐ Oceans ☐ Lakes ☐ Rivers ☐ Pools ☐ Quarries ☐ Caves ☐ Other ______

Have you received formal diving training? ☐ Yes ☐ No (If "Yes," give details in Remarks below.)

Do you use the "buddy system"? ☐ Yes ☐ No

| **Depth** | **Average Time** | **Number of Dives Last 12 Months** | **Number of Dives 1 to 2 Year Ago** | **Number of Dives Est. Next 12 Months** |
|---|---|---|---|---|
| O - 75 ft. | Mins. | | | |
| 75 - 125 ft. | Mins. | | | |
| Over 125 ft. | Mins. | | | |

**Section III**

**Sky Sports**

☐ Sky Diving ☐ Hang Gliding ☐ Ultralights ☐ Biplaning ☐ Parachuting ☐ Ballooning ☐ Other ______

If sky diving:

Delayed jumping done? . . . . . . . . . ☐ Yes ☐ No

Any stunting or baton passing? . . . . . ☐ Yes ☐ No

If ballooning:

Gas ballooning . . . . . . . ☐ Yes ☐ No

Hot air ballooning . . . . . . ☐ Yes ☐ No

Are you a member of a club? . . . . . . . ☐ Yes ☐ No

What class of license do you hold? . . . . ______

Usual location or type of terrain . . . . . ______

Have you been in an accident connected with this avocation? ☐ Yes ☐ No (If "Yes," give details in Remarks below.)

Number of flights or jumps: Last 12 Mos. ______ 1 to 2 Years Ago ______ Est. Next 12 Mos. ______

Average height ______ Maximum height ______

Average distance ______ Maximum distance ______

Average duration ______ Maximum duration ______

**Remarks:**

**The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.**

Signed at ______
City and State

(X) ______
Signature of Proposed Insured

Date ______