

ADA TERM PLUS[®] UNIVERSAL LIFE PLAN

Application for Insurance



QUESTIONS?



TOLL-FREE
888-463-4545



WEB
www.insurance.ada.org



E-MAIL
ada@gwl.com

READY TO GO?



FAX
303-737-4843



P.O. Box 340
Denver, CO 80201

ULWS08

PERSONAL INFORMATION

ADA Member: Please provide personal identification and contact information here. Complete all sections on application, then sign and date on back.

ADA Identification No. _____

Home Phone _____

Name _____

Office Phone _____

Address _____

Cell Phone _____

City _____

Fax Number _____

State _____ Zip _____

E-mail _____

Are you an ADA or ASDA member under age 65? Yes No

Best way to be contacted (if needed): Phone Fax E-mail

Best time to be contacted: M T W Th F at ____:____ am pm

PAYMENT INFORMATION

Please complete this section ONLY if you are applying for coverage for the first time. Send no money now; accepted applicants will be billed upon approval. If you are an existing participant in this Plan and wish to change your payment preference, please call 800-568-2001 for assistance.

I wish to make contributions:*

- Annually
- Semi-annually
- Quarterly
- Monthly**

- By check
- By Autopay bank withdrawal:
 - 1st of the month
 - 10th of the month
 (Monthly frequency only)

If selecting Autopay, please attach your voided check here.

Autopay Terms and Conditions: All monthly withdrawals will be made, as elected, on the 1st or 10th of the month in which premium is due. Autopay will terminate (1) when you (or the bank depositor, if other than the Certificate owner) provide Great-West Life 30 days written notice; or (2) at Great-West Life's election, upon 30 days written notice to you and/or the bank depositor; or (3) at the discretion of Great-West Life, if your designated bank does not transfer funds. In this case, you will receive notification from Great-West Life, and an opportunity to designate another form of payment. Should the Autopay program terminate, you will be notified to select another payment preference.

For bank withdrawals, please provide the following information and attach a voided check to your application.

Bank name _____

*Contributions are deposited into a Policy Value Account, from which your Cost of Insurance and a nominal service fee will be automatically deducted each month. All contributions will accrue interest from the date of deposit.

Account number _____

Account holder's name (if other than yourself) _____

** You may submit deposits by check on any day of the month. 10th of the month is only available if you elect the Monthly frequency and the Autopay option.

Account type: Savings Checking

COVERAGE INFORMATION

All elections made here will override any previous elections. (Call 800-568-2001 to verify your existing elections.) For Questions 2A and 2B: A "YES" response will be assumed if neither box is checked. A "NO" response will constitute an official request for immediate termination of any existing Optional coverage, which will be subject to underwriting approval if you wish to apply for it again in the future.

1 I am requesting this amount of ADA Term Plus Universal Life insurance coverage: **Please write in the TOTAL amount of coverage desired (INCLUDING any existing coverage under this plan). Minimum amount for new or increase is \$50,000; you may request up to \$2,000,000 in any combination of ADA Term Plus and ADA Term Life, in \$25,000 increments.**

\$ _____

2 Optional Coverage: You may request up to three types of Optional coverage:

- A** Yes No **Accidental Death Insurance:** Doubles your death benefit, up to a maximum of \$1,000,000, if your death is by accidental means
- B** Yes No **Disability Waiver of Premium:** Allows all coverage to continue without premium payment if you become totally disabled prior to age 60
- C** Yes No **Dependent Coverage:** Please send me an ADA Term Life application so I can request coverage for my spouse or domestic partner and/or each eligible unmarried dependent child

3 The amount of my Recommended Annual Premium, as shown on my personal plan illustration, is: **This amount is based on your age, your insurance amount, and your individual saving goals. Call a Plan Specialist at 888-463-4545 to request a personal plan illustration.**

\$ _____

BENEFICIARY DESIGNATION

Please print. Percentages must total 100%.

- No beneficiary change at this time
- I hereby revoke any previous beneficiary designation I may have made and appoint the person(s) named here as the beneficiary of any monies payable upon my death.

Full Name	Relationship	Percent of Benefit
_____	_____	_____%
_____	_____	_____%

HEALTH INFORMATION

Please also complete medical questionnaire on back.

Birthdate _____ / _____ / _____ Male Female Height _____
month day year Weight _____ lbs

Current Personal Physician _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

MEDICAL QUESTIONNAIRE FOR ADA TERM PLUS® UNIVERSAL LIFE PLAN

Please answer all questions and explain any "Yes" answers below (attach additional sheet if necessary).

1. Has your weight changed in the past year by plus or minus 10 pounds or more?
If yes, please indicate gain or loss and number of pounds. Yes No
2. Have you ever had or been treated for high blood pressure, elevated cholesterol, heart problems, diabetes, cancer, kidney disorder, stomach complaints, arthritis, or other joint disease? Yes No
3. Have you ever been treated for anxiety, depression, or other emotional disturbances? Yes No
4. Have you ever applied for insurance which was declined, postponed, or modified in any way? Yes No
5. Have you had a checkup, consultation, illness, surgery, injury, or disease not mentioned in the questions above? Yes No
6. **Foreign Travel:** Do you plan to travel to or reside in a country other than the U.S.A. at any time in the next two years?
If yes, identify all anticipated travel and lengths of stays. Yes No
7. **Aviation:** Have you ever flown a private aircraft or do you intend to fly as a pilot or crewmember? Yes No
8. **Avocations/Hobbies:** Do you now or do you intend to participate in sky diving, hang gliding, parachuting, racing motor vehicles, or any other hazardous or extreme sports? Yes No
9. **Family Health History:** Did either of your parents or any of your siblings die prior to age 60 due to coronary heart disease, diabetes, cancer, or stroke? Yes No
10. **Motor Vehicle Use:** In the last five years have you had any motor vehicle accidents or moving violations or had your drivers license revoked or suspended? Yes No
11. **Use of Nicotine:** Do you now or have you ever smoked cigarettes, cigars, or used nicotine products in any form?
If yes, give details including the date you last consumed nicotine if you have quit. Yes No
12. **Alcohol or Drugs:** In the past ten years:
 - a. Have you ever used narcotics, barbiturates, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician? Yes No
 - b. Have you self prescribed any of these substances? Yes No
 - c. Have you ever received treatment or counseling for the use of alcohol or other habit forming substances? Yes No

If you answered "Yes" to any of the above medical questions, please explain in detail below. If space is not adequate, attach another sheet.

Question	Dates	Reason Consulted/Diagnosis	Physician's Name, Address, and Phone Number	Current Status

NOTICE TO APPLICANTS

Information regarding your insurability will be treated as confidential. Great-West Life & Annuity Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit 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 it may have in its files.

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 files, 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 P.O. Box 105, Essex Station, Boston, MA 02112.

Great-West Life & Annuity Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted and to any other persons as allowed by law.

The insurance will become effective on the date the application is approved by

the Company.

A medical examination by an examiner, approved by the Company, may be requested for any applicant. The fee for the examination will be paid by the Company. Applicants accepted for insurance will receive insurance certificates stating the terms and provisions of the group policy. Applicants not accepted for insurance will be informed promptly.

I hereby apply for insurance under Group Policy 104ULP issued by Great-West Life & Annuity Insurance Company to the American Dental Association subject to all terms, conditions, and provisions of said policy.

By my signature below, I hereby declare that my answers and statements to the questions contained herein are full, complete, and true and a condition of obtaining this insurance. I understand and agree that knowingly providing false, incomplete, or misleading information as a part of this application, or in filing a claim, may constitute fraud which may result in the denial of claims, the rescission of coverage, and potential criminal penalties. I have the right to access my personal medical and financial information in my files and to request that any inaccurate information be corrected.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

- A. Great-West Life & Annuity Insurance Company, its reinsurers, and insurance support organizations may obtain medical and other information in order to evaluate my application for life insurance.
- B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer, and consumer reporting agency or insurance company who possesses information of care, treatment, or advice of me may furnish such information to Great-West Life upon presenting this authorization or a photocopy.
- C. This authorization includes information about drugs, alcoholism, and

mental illness.

- D. Great-West Life or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply.
- E. The authorization will be valid from the date signed for a period of two and one-half years.
- F. I authorize Great-West Life to obtain an investigative consumer report on me.
- G. I have read this authorization and the "Notice to Applicant" and I may obtain a copy of the Description of Information Practices on request.

SIGNATURES *Ensure that owner signs if owner and applicant are not the same.*

Signature of Member **X** Date / /

Signature of Owner (if applicable) **X** Date / /

California Disclosure: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Pennsylvania Disclosure:** 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. **New York Disclosure:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.