THE
CINCINNATI LIFE INSURANCE COMPANY
6200 SOUTH GILMORE ROAD, FAIRFIELD, OHIO 45014-5141
Mailing Address: P.O. Box 145496, CINCINNATI, OHIO 45250-5496

Traditional Life Application Packet

Instructions:

- Thoroughly complete the attached application and proper state replacement form(s), if applicable. Be certain your agent name, agency name and code numbers are legible. Consult the Agent's checklist in the Life Underwriting Handbook, Form CLI-8430, for guidance in providing details that will expedite the underwriting process.

- If the payment mode selected is Bank-O-Matic, a Pre-Authorized Withdrawal Agreement form must be completed. Attach a voided check from the account to be used.

- Leave the following forms with the applicant:
  - Conditional Premium Receipt (If full modal premium was collected)
  - Important Notice to the Proposed Insured

- If medical requirements are required for this age and amount, as outlined in the current Medical Underwriting Requirements pamphlet, Form CLI-8334, make arrangements for them to be completed by your preferred paramedical service. APPS, EMSI, ExamOne and Portamedic are all approved to complete medical services for us and have our supplies. Please note that ExamOne and Portamedic are the ONLY paramedical services approved to perform the Mature Assessment.

- The following forms, with original signatures, should be mailed to Headquarters at the above address as soon as possible:
  - Original application
  - State required HIPAA Authorization
  - HIV consent form (where applicable; if blood profile is required)
  - Medical Authorization
  - Pre-Authorized Withdrawal Agreement and voided check
  - Premium check
  - Replacement Form(s) (where applicable)
  - Signed illustration or certification (where applicable)

Forms Included:

Authorization for Release of Information Form CLI-6260
Life Insurance Application Form CLI-1030-CA
Pre-Authorized Withdrawal Agreement Form CLI-6261 (7/07)
Important Notice to the Proposed Insured Form CLI-6273-CA
Notice of Privacy Practices Form MI1659 (4/08)

THE CINCINNATI LIFE INSURANCE COMPANY

P.O. Box 145496, Cincinnati, Ohio 45250-5496

Application for Life Insurance ☐ **NEW** ☐ **CHANGE** **Please print or type all information**

INSURED

1. Proposed Insured (first, middle, last)	2. Birth Date	3. Gender ☐ M ☐ F	4. Height	5. Soc. Sec. No.
	6. Birthplace (state)		7. Weight	8. Phone Home _____ Work _____
9. Street Address Apt. # City State Zip				10. Driver's Lic. No./State

11. Has the Proposed Insured been a permanent resident of the United States or its territories for the last three years? ☐ Yes ☐ No (If "No," please explain in #39)

12. Is the Proposed Insured actively employed? ☐ Yes ☐ No (If "No," please explain in #39)
Occupation _____ Employer _____ Hours Per Week____

BENEFIT

13. Primary Beneficiary Relationship	14. Contingent Beneficiary Relationship

15. Owner (if other than Proposed Insured) Address Relationship	16. Soc. Sec. No./EIN (if business)
	17. E-mail Address

18. Plan Face Amount	19. UL Death Benefit Option ☐ A ☐ B

20. Optional Benefit Riders

☐ Accidental Death Benefit	$ _____ Amount	☐ Waiver of Premium/Cost of Insurance	
☐ Children's Term (complete #37)	_____ Units	☐ Accelerated Benefit (submit disclosure if required)	
☐ Insured Insurability (GPO)	$ _____ Amount	Rider_____	Rider_____

21. Premium Mode ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ List Bill ☐ Bank-O-Matic (complete authorization)

22. Amount Remitted with Application $_____ 23. Automatic Premium Loan (if available) ☐ Yes ☐ No

COND. RECEIPT

CONDITIONAL RECEIPT QUESTIONS
If Questions 24, 25 or 26 Are Left Blank or Answered "Yes," a Premium Payment Cannot Be Accepted and Any Conditional Receipt Will Be Void.

	Yes	No
24. In the past 90 days, has the Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, scheduled surgery or had surgery performed or recommended?	☐	☐
25. In the past two years, has the Proposed Insured been treated by a medical professional for heart disease, stroke, cancer or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
26. Does the Proposed Insured have any intention to travel outside the United States or Canada within the next 90 days?	☐	☐

PERSONAL HISTORY

GIVE FULL DETAILS TO ANY QUESTIONS ANSWERED "YES" IN #39

27. Has the Proposed Insured:	Yes	No
a. In the last three years, flown or made plans to fly as a pilot, student pilot or crew member? (If "Yes," complete Aviation Questionnaire)	☐	☐
b. Traveled or resided outside the USA or Canada in the last two years, or have any intention of traveling or residing outside the USA or Canada within the next two years?	☐	☐
c. Engaged in sky or scuba diving, hang gliding, rock climbing or any form of motorized racing in the last three years, or have any intention of engaging in any of these activities within the next two years? (If "Yes," complete Sports Questionnaire)	☐	☐
d. Ever used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, marijuana, any derivative of these drugs or any controlled substance except as prescribed by a medical professional?	☐	☐
e. Ever received or been advised to seek counseling for alcohol and/or drug abuse?	☐	☐
f. Ever been rated or declined for insurance or been denied reissue or reinstatement of a policy?	☐	☐
g. Ever been convicted of a felony?	☐	☐
h. In the last three years, had two or more traffic violations, been convicted of driving while intoxicated or under the influence of a controlled substance or ever had his/her license suspended or revoked?	☐	☐
28. Does the Proposed Insured belong to or intend to join the armed forces including reserves? (If "Yes," complete Military Questionnaire)	☐	☐
29. Has the Proposed Insured ever filed for bankruptcy? If "Yes," date(s) discharged _____	☐	☐

THE CINCINNATI LIFE INSURANCE COMPANY

P.O. Box 145496, Cincinnati, Ohio 45250-5496

In continuation of application for life insurance

PERSONAL HISTORY

30. In the last ten years, has the Proposed Insured had or been told by a medical professional he/she had, any of the following? (If "Yes," check the items that pertain) ..... **Yes** ☐ **No** ☐

☐ Stroke	☐ Prostate disorder	☐ Lung or respiratory disorder
☐ Diabetes	☐ High blood pressure	☐ Disease of the reproductive organs
☐ Hepatitis	☐ Digestive system disorder	☐ Deformity, lameness or amputation
☐ Chest pain	☐ Mental or nervous disorder	☐ Muscle or connective tissue disorder
☐ Skin disorder	☐ Cancer or tumor of any kind	☐ Thyroid or other endocrine disorders
☐ Bone disorder	☐ Spine, back or joint disorder	☐ Disorder of the blood or lymph nodes
☐ Seizure disorder	☐ Dizziness, fainting or headache	☐ Disease of the heart or blood vessels
		☐ Kidney or bladder disease or disorder

31. Has the Proposed Insured: **Yes** **No**

a. In the last five years, been hospitalized or consulted, been examined or treated by any physician, psychiatrist or other medical professional not disclosed in response to the prior questions? ..... ☐ ☐

b. Ever been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? ..... ☐ ☐

c. Been advised to have surgery within the next six months by a medical professional? ..... ☐ ☐

32. Is the Proposed Insured taking any prescribed medication or herbal treatment? ..... ☐ ☐

33. Female Proposed Insured only: Is the Proposed Insured now pregnant? ..... ☐ ☐

34. Has the Proposed Insured ever used tobacco or nicotine products? (If "Yes," complete the following) ..... ☐ ☐

	Present	Quit (date)		# Packs Per Day	Present	Quit (date)
Cigar	☐	_____	Cigarettes	_____	☐	_____
Pipe	☐	_____	Patch, Gum or Other			
Smokeless	☐	_____	Nicotine Products		☐	_____

35. Proposed Insured's Regular Attending Physician (If "None," so state)

_____ Name _____ Address

_____ Phone # _____ Date of Last Visit _____ Reason/Result of Last Visit

36. Have any of the Proposed Insured's parents, brothers or sisters died from, or been diagnosed by a medical professional as having, heart disease or cancer before age 60? (If "Yes," identify family members, disorder and age at death in #39) ..... **Yes** ☐ **No** ☐

CTR

37. **CHILDREN'S TERM RIDER**

Available for all children, stepchildren or legally adopted children age 18 and under.

Name	Date of Birth	Height	Weight
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other than a routine physical, has any child been treated by a medical professional or been hospitalized in the past two years? (Please explain "Yes" answers in #39) ..... **Yes** ☐ **No** ☐

EXISTING COVERAGE

38. a. Does the Proposed Insured have any life insurance policies or annuities in force with The Cincinnati Life Insurance Company or any other company? ..... **Yes** ☐ **No** ☐

b. Do you intend to finance any of the premium required to pay for this policy? ..... ☐ ☐

c. Have you ever or are you considering selling this or any other life insurance contract to a Viatical or Life Settlement company or any other party? ..... ☐ ☐

d. List all life insurance policies or annuities the Proposed Insured has in force with The Cincinnati Life Insurance Company or any other company, including any applications pending, and indicate if any are to be replaced, changed or borrowed against as a result of this Application.

Insurer	Policy Number	Amount	Replaced? Yes	No
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐

e. Complete any applicable replacement forms.

THE CINCINNATI LIFE INSURANCE COMPANY
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In continuation of application for life insurance

DETAILS

39. **DETAILS OF "YES" ANSWERS:** Identify question number and include diagnosis, dates, duration, treatments and medications prescribed and names and addresses of all medical professionals and hospitals.

_____
_____
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AGREEMENT

AGREEMENT: I, the undersigned, agree that, to the best of my knowledge and belief, all the answers and statements given in this Application are true and complete. I agree that: 1. All parts of this Application will be a part of any policy issued; 2. Insurance shall become effective: a) if a policy is formally approved by The Cincinnati Life Insurance Company; and b) the full first premium has been paid while insurability of the Proposed Insured is the same as stated in this Application; OR c) according to the terms of the Conditional Receipt if: (i) it is given; and (ii) the full first premium is paid when this Application is signed; 3. No provision of this Application or the policy can be modified or waived except by an endorsement signed by an officer of The Cincinnati Life Insurance Company. I have read, or had read to me, the completed Application. I realize that any false statement or misrepresentation may result in loss of coverage under the policy.

If a Conditional Receipt is given: I, 1. acknowledge receipt; 2. certify that I have read and understand it; 3. agree to its terms, conditions and limits; and 4. acknowledge that the agent has explained it to me.

I acknowledge having received and read the Important Notice to the Proposed Insured.

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.

Signed at _____ _____ On _____
City State Month Day Year

_____ _____
Signature of Proposed Insured (if signing on behalf of a minor, specify relationship)
Signature of Owner (if other than Proposed Insured)

AGENT

For Agent: I certify, to the best of my knowledge and belief, that the answers to the questions in all parts of this application are true and correct. I further certify that to the best of my knowledge and belief, this policy ☐ **Will** ☐ **Will Not** replace or change any existing life insurance or annuity contract now in force. I certify that I have provided the Applicant with a copy of The Cincinnati Life Insurance Company's Notice of Privacy Practices.

_____ _____ _____
Agent Signature Agent Code # Fax Number

_____ _____
Agent Name (please print) E-mail Address

_____ _____
Agency Name (please print) Agency Code #

THE CINCINNATI LIFE INSURANCE COMPANY

P.O. Box 145496, Cincinnati, Ohio 45250-5496

In continuation of application for life insurance

CONDITIONAL PREMIUM RECEIPT - MAXIMUM LIABILITY $300,000

PLEASE ANSWER CONDITIONAL RECEIPT QUESTIONS ON PAGE ONE OF APPLICATION. If any of the questions are left blank or answered "Yes," a premium payment cannot be accepted and any conditional receipt will be void.

Received from _____ Owner's Social Security or EIN # _____

Proposed Owner (please print)

On _____ the amount of $ _____

Month Day Year Must be Full Modal Premium

which is paid subject to the conditions of this Receipt as payment of the full first premium of the life insurance policy applied for in a written application to The Cincinnati Life Insurance Company.

Section I: If the Proposed Insured dies before we, The Cincinnati Life Insurance Company, issue and deliver the policy, this Receipt may create temporary life insurance coverage. Such coverage will not exist unless each of the following conditions is fulfilled exactly:

1. The premium deposit must be a full first premium at the premium mode and plan applied for. The premium must be paid at the time the Application is signed. This Receipt must be issued at the same time.
2. We must receive the total premium deposit at our Home Office.
3. The premium check must be paid the first time it is presented.
4. We must receive the Application and all medical examinations or tests we request or which our underwriting rules require. We must receive these papers not later than 60 days from the date of this Receipt.
5. Our Underwriters must formally determine that on the latest of: a) the date of the Application; or b) the date of the latest medical examination or test that we require, the Proposed Insured was acceptable to us under our rules, limits and standards. The Proposed Insured must qualify for the exact plan and amount of insurance applied for and for all supplemental riders applied for. The Proposed Insured must be insurable at standard premium rates.
6. No temporary insurance will be effective if any incorrect, untrue or incomplete statement of material fact is made on: a) the Application; or b) any report of any examination or medical test submitted to us. Knowledge of the true facts by the agent or medical examiner shall not be imputed to us unless stated in the Application or in a medical report received in our Home Office.

Section II: Temporary insurance under this Receipt is also subject to these limitations:

1. Maximum temporary life and accidental death insurance cannot exceed $300,000. This amount will be reduced by any other life insurance applied for or in force with us. This amount will also be reduced by any other accidental death insurance applied for or in force with us.
2. Temporary insurance may be in effect for up to 60 days from the date of this Receipt.

Temporary insurance will become effective if each of the six conditions in Section I is fulfilled exactly. This coverage is subject to the limitations in Section II. The effective date of this coverage will be either the date of the last dated Application or the date of the last required medical test, if later.

Temporary insurance shall terminate on the earliest of the following dates:

1. The date a policy becomes effective;
2. The date we determine the Proposed Insured doesn't qualify as a standard risk and elect to terminate the temporary insurance;
3. The date we formally approve a policy: a) on a different plan; b) for a different amount; or c) at a substandard premium rate;
4. The date when we formally determine not to offer any policy; or
5. 60 days from the date of this Receipt.

If we issue and physically deliver to the proposed owner a policy on the Application, we will apply the premium received with the Application to pay the first premium. We will refund the premium received with the Application if: a) we terminate the temporary insurance; b) we issue no policy; or c) the proposed owner doesn't accept the policy as provided in the Right to Examine Policy provision of the policy.

THIS IS NOT A BINDER. NO BROKER, AGENT OR MEDICAL EXAMINER CAN ACCEPT RISKS, APPRAISE INSURABILITY OR BIND US. NO SUCH PERSON IS AUTHORIZED TO WAIVE OR CHANGE ANY TERMS OF THIS RECEIPT OR ANY OTHER RIGHTS OF THE CINCINNATI LIFE INSURANCE COMPANY. WE WILL EITHER ISSUE THE AMOUNT OF INSURANCE APPLIED FOR OR REFUND THE AMOUNT OF THE PREMIUM DEPOSITED.

_____ Date _____

Signature of Agent Month Day Year

THE CINCINNATI LIFE INSURANCE COMPANY

P.O. Box 145496, Cincinnati, Ohio 45250-5496

AGENT'S REPORT

This report should always be completed and remain attached.

Source of Business:	☐ Present Insured: Type_____ ☐ Personal Acquaintance (not Proposed Insured) ☐ Cold Call ☐ Referral from Outside Agency ☐ Reply to Mailer or Stuffer ☐ Internet Source ☐ Other: _____
Purpose of Insurance:	Personal: ☐ Estate Conservation ☐ Family Protection ☐ Charitable ☐ Other: _____ Business: ☐ Key Person ☐ Buy-Sell ☐ Creditor ☐ Partnership ☐ Sole Proprietor ☐ Corporation ☐ Other: _____
Juvenile Proposed Insured:	**Yes** **No** Was the child seen when the application was taken? ..... ☐ ☐ Are all siblings insured for equal amounts? ..... ☐ ☐ Are the parents insured for at least the same amount applied for and in force on this child? ..... ☐ ☐
Amount of Insurance:	The death benefit amount was determined by: (check all that apply) ☐ Needs Analysis Software ☐ Multiple of Income ☐ Cost of Final Expense ☐ Insured ☐ Other: _____
Rate Class:	Rate Class Quoted:

COMMISSIONS - SPLIT CASE

First year and renewal

Agent Commission Schedule Only		General Agent Base Commission Schedule	
Case Split %	Name	Agency Code #	Agent Code #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
100%	Sum of percentages listed must be 100%. Percentages are Case Split ratios, not commission rates.		

THE
CINCINNATI LIFE INSURANCE COMPANY

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

NOTICE AND CONSENT FOR BLOOD TESTING WHICH INCLUDES AIDS VIRUS (HIV) ANTIBODY TESTING

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory. A test will be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The series consists of two ELISA tests followed by a Western Blot test. The test is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of MIB and if the test result for HIV antibodies is other than normal, the Insurer will report to MIB a generic code which signifies only a non-specific blood test abnormality. If your HIV antibody test is normal, no report will be made about it to MIB. Other test results may be reported to MIB in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV antibody test result is normal, no routine notification will be sent to you. If the HIV antibody test result is other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

A positive HIV antibody test result does not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. A negative HIV antibody test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not necessarily mean that you have not been infected with the virus.

A positive HIV antibody test result or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Additional information concerning the meaning of the test and the interpretation of the results of the test may be obtained from a private physician, the County Department of Health, the State Department of Health Services, local Medical Societies or Alternative Test Sites.

CONSENT

I have read and I understand this Notice and Consent For Blood Testing Which Includes AIDS Virus (HIV) Antibody Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize the insurer to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Physician's Name: _____

Physician's Address: _____

_____

_____

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This authorization is valid for six months.

_____ _____

Proposed Insured Date of Birth

_____ _____ _____

Signature of Proposed Insured or Parent/Guardian | Date | State of Residence

THE
CINCINNATI LIFE INSURANCE COMPANY

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

THE IMPORTANT NOTICE PRINTED BELOW MUST BE GIVEN TO THE PROPOSED INSURED

IMPORTANT NOTICE TO THE PROPOSED INSURED

I (We) understand that The Cincinnati Life Insurance Company may obtain an investigative consumer report on me. The report will be prepared by ExamOne, 10101 Renner Blvd., Lenexa, Kansas, 66219, 1-877-933-9261. The data for the report may be obtained through personal interviews with my neighbors, friends, associates or acquaintances. This report includes information about my health, character, reputation, occupation, personal characteristics, mode of living and finances. I understand that: 1. I may request to be interviewed if an investigative consumer report is obtained; 2. With proper identification generally deemed sufficient to identify a person, I may obtain the report: a) in person at the office of ExamOne. I may bring one other person with me who must also submit proper identification; b) by certified mail upon submission of a written request; or c) by telephone, the charges for which I will be responsible; 3. ExamOne will: a) provide trained personnel to explain any information; and b) provide a written explanation of any coded information; 4. ExamOne will be available during normal business hours and on reasonable notice; and 5. I have the right to access and request correction with respect to all personal information collected.

Information regarding your insurability will be treated as confidential. The Cincinnati Life Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Cincinnati Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at *www.mib.com*.

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P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

IMPORTANT NOTICE

This policy is similar to a term policy for the same level premium period, but does not provide any nonforfeiture benefits (such as cash surrender values) at any time during those years. This means that if you fail to pay a premium within a specified time of its due date, this policy will lapse without any value.

You should compare this policy to a level-premium term policy. Such a term policy would provide identical insurance coverage, but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for the term policy might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.

THE
CINCINNATI LIFE INSURANCE COMPANY
P.O. BOX 145496
CINCINNATI, OHIO 45250-5496
FAX (513) 870-2095

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF MONTHLY PREMIUM PAYMENTS

The person paying the premium on the life insurance policies listed below must sign this agreement.

I request and authorize The Cincinnati Life Insurance Company to draw against the account listed below to pay premiums on the following policies:

Policy Number (if known)	Name of Insured

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Account: ☐ **Checking** ☐ **Savings** **Account Number:** _____

1. **Funds will be withdrawn on the Policy/Contract Date.**
   If a different withdrawal date is desired, please indicate date: _____
   Month Day
2. **The payment of the premiums in this manner may be discontinued at any time by The Cincinnati Life Insurance Company with 30 days' notice, or without notice if any draw is not paid upon presentation.**
3. **This authorization is revocable by the undersigned upon receipt by The Cincinnati Life Insurance Company of written notice.**
4. **If any such draw is dishonored, the premium for which the draw is made shall be considered in default.**

_____
Premium Payer – Depositor (please print)

_____ _____
Date: Month Day Year **Signature of Premium Payer – Depositor**

IF TYPE OF ACCOUNT IS CHECKING PLEASE INCLUDE A VOIDED CHECK WITH AUTHORIZATION. DO NOT USE STAPLES.

Form CLI-6261 (7/07)

THE
CINCINNATI LIFE INSURANCE COMPANY

P.O. Box 145496, Cincinnati, Ohio 45250-5496

Authorization for Release of Information

I hereby authorize any licensed physician; medical practitioner; hospital, clinic or other medical or medically related facility; the Veterans Administration; MIB; any prescription data base service; my employer; and consumer reporting agency or insurance company that has any records or knowledge of the Proposed Insured identified below or his or her health, to furnish such information to The Cincinnati Life Insurance Company, its employees, reinsurer(s), administrative services provider and any other authorized representative upon presenting this authorization.

This authorization includes information about mental illness and the use of drugs, alcohol or tobacco (excluding psychotherapy notes); sexually transmitted disease; Human Immunodeficiency Virus (HIV) infection; Acquired Immune Deficiency Syndrome (AIDS); and the diagnosis, treatment or prognosis of any physical condition.

I understand that:

1. This authorization may be required in order for my application for insurance to be evaluated and a policy issued;
2. This authorization will be valid from the date signed for a period of two years;
3. A photographic copy of this authorization shall be as valid as the original;
4. Any request that I have made to restrict information disclosed does not apply to this authorization. I instruct the providers and entities listed in the first paragraph of this authorization to release and disclose my entire medical record without restriction;
5. The information disclosed under this authorization will be used and may be subsequently disclosed by The Cincinnati Life Insurance Company to: a) underwrite and rate my application for insurance and make eligibility and enrollment determinations; b) obtain reinsurance; c) process other transactions related to my policy; and d) conduct other legally permissible or required activities that relate to any coverage I have or have applied for with The Cincinnati Life Insurance Company;
6. I may obtain a copy of this authorization form by sending a written request to The Cincinnati Life Insurance Company at the above address;
7. I may revoke this authorization at any time by sending a written request to The Cincinnati Life Insurance Company at the above address, but revocation will not affect information that has already been collected and relied upon; and
8. Information disclosed pursuant to this authorization will not be redisclosed by The Cincinnati Life Insurance Company except as described above or as otherwise permitted or required by law. I understand that information disclosed pursuant to this authorization may no longer be subject to federal privacy regulations and laws.

Signed on: _____
Month Day Year

_____ _____

Name of Proposed Insured (please print)

Signature of Proposed Insured (if signing as personal representative, specify relationship to Proposed Insured)

_____ _____

Name of Other Proposed Insured (please print)

Signature of Other Proposed Insured (if signing as personal representative, specify relationship to Other Proposed Insured)

Form CLI-6260

THE
CINCINNATI INSURANCE COMPANIES

THE CINCINNATI INSURANCE COMPANY
THE CINCINNATI CASUALTY COMPANY
THE CINCINNATI INDEMNITY COMPANY
THE CINCINNATI LIFE INSURANCE COMPANY
THE CINCINNATI SPECIALTY UNDERWRITERS INSURANCE COMPANY
Mailing Address: P.O. BOX 145496
CINCINNATI, OHIO 45250-5496
513-603-5992

NOTICE OF PRIVACY PRACTICES

OUR PRIVACY PLEDGE

You have received this notice because you have a policy with us or you have applied for or purchased a product or service from our family of companies. We believe that your personal information should be respected and protected. For this reason, we are committed to protecting your personal information and using it only as appropriate to provide you with the best possible service, products and opportunities.

This privacy notice describes our information practices and policies. It applies to our relationship with you if you are an individual who inquires about or obtains products or services from us for personal, family or household purposes.

INFORMATION WE COLLECT

To provide our products or services, we may collect personal information about you from a variety of sources, including:

- information that comes from you during the application process or when visiting *www.cinfin.com*
- information about you from our affiliates, your independent insurance agent, governmental entities, consumer-reporting agencies and other sources
- with your prior written consent, a medical professional who has treated you or members of your family

The type of information that we collect depends on the product or service requested, but may include:

- credit history
- motor vehicle reports
- inspections on your property
- claims history
- information concerning your previous insurance policies
- information to properly investigate and resolve any claims

INFORMATION WE DISCLOSE TO THIRD PARTIES

We do not sell your personal information to anyone. We do not disclose your personal information to third parties - people and companies that are not affiliated with us - for their own marketing purposes. For this reason, no "opt-out" is required. If we share some personal information about you with third parties without your specific authorization, it is to provide you with products and services that you request or expect from us, and as otherwise permitted by law.

For example, we may disclose the personal information we collect (as described above) as necessary to:

- service your policy, lease or account
- investigate and pay claims
- comply with state and federal regulatory requests or demands
- process other transactions that you request

To whom we make such disclosures depends on the product or service requested but may include:

- your independent insurance agent
- insurance regulators
- reinsurance companies
- consumer-reporting and fraud prevention agencies
- your mortgage or premium finance company
- insurance adjusters

We also may disclose personal information about you to companies that perform marketing services on our behalf or to other financial service providers with which we have joint marketing agreements. If information is disclosed, it will not result in telemarketing or direct mail marketing.

INFORMATION SECURITY

We restrict access to personal information about you to those employees who need access to that information in order to provide products and services to you. We maintain physical, electronic and procedural safeguards to guard your personal information.

A SPECIAL WORD ABOUT OUR INSURANCE INFORMATION PRACTICES

The information in this section applies to you only if you applied for or purchased an insurance product from us for personal, family or household purposes. This section is intended to supplement, but not replace, the other information contained in this Notice of Privacy Practices.

You have the right to access the personal information that we collect about you in connection with your insurance transactions with us. If you believe that any of that information is in error, you have the right to request us to correct it. Send your written request, including your policy number and the information about which you are concerned, to the address listed below.

To receive a more detailed notice regarding our insurance information practices and your information privacy rights, please contact us at the address or phone number given below.

E-MAIL COMMUNICATIONS

We will **not** send you an e-mail in which we ask for personal information from you (such as password or Social Security number) or link you to our Web site to ask you for such information unless we reference a specific transaction or information that you have requested. If you receive an unsolicited or suspicious e-mail from The Cincinnati Insurance Companies, please forward the e-mail to us at *privacy@cinfin.com*.

INFORMATION WE SHARE WITHIN OUR CORPORATE FAMILY

To serve you, we may share information about our experiences and transactions with you within our family of companies. Such information may include your payment or claims history or the types of insurance coverages you purchase from us.

The following companies comprise the Cincinnati Financial Corporation family of companies:

- Cincinnati Financial Corporation
- The Cincinnati Insurance Company
- The Cincinnati Casualty Company
- The Cincinnati Indemnity Company
- The Cincinnati Life Insurance Company
- CFC Investment Company
- The Cincinnati Specialty Underwriters Insurance Company
- CSU Producer Resources Inc.

This privacy notice applies to and is provided on behalf of all of the companies in the Cincinnati Financial Corporation family of companies with the exception of CFC Investment Company, which is governed by a separate and specific privacy policy.

ONGOING ACCESS TO OUR PRIVACY POLICY

We will provide a notice of our privacy policy annually, as long as you have a continuing customer relationship with us. This policy may change from time to time, but you can always review our current policy by visiting our Web site at *www.cinfin.com* or by contacting us at:

The Cincinnati Insurance Companies
Attn: Regulatory & Consumer Relations - Privacy
P.O. Box 145496
Cincinnati, Ohio 45250-5496
Phone: 888-744-2170 (toll free) or 513-603-5992
E-mail: *privacy@cinfin.com*

THE
CINCINNATI LIFE INSURANCE COMPANY

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496
(513) 870-2000

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature	Date	Agent's Signature

The following policy(ies) may be replaced as a result of this transaction:

Insurer and Address as it appears on the policy	**Insured as it appears on the policy**	**Policy Number**

Form CLI-6288-CA **Original to Home Office – Copy to Applicant**

THE

CINCINNATI LIFE INSURANCE COMPANY

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

FOREIGN TRAVEL & RESIDENCE QUESTIONNAIRE

Proposed Insured: _____ Policy # _____

1. Current citizenship: _____

2. Visa type, symbol, number and expiration date (if applicable):

_____

3. Employer: _____

Occupation/Duties:

_____

4. Have you traveled or resided outside the United States in the past two years?..... ☐ Yes ☐ No

If "yes," please complete the following table:

City and Country Visited	Dates of Stay *(Duration)*	Purpose of Travel *(Business, pleasure, family visit, etc.)*

5. Do you plan to travel or reside outside the United States in the next 12 months? ..... ☐ Yes ☐ No

If "yes," please complete the following table:

City and Country Visiting	Expected Dates of Stay *(Duration)*	Purpose of Travel *(Business, pleasure, family visit, etc.)*

6. Describe your accommodations while traveling:

_____

_____

7. Describe your modes of transportation while traveling: _____

_____

_____

The statements and answers above are complete and true to the best of my knowledge and belief.

Date: _____ _____

Month Day Year Signature of Proposed Insured

Form CLI-6270