

Ohio National Life Assurance Corporation/ Cincinnati
P. O. Box 5409, Cincinnati, Ohio 45201-0237

About your Term Life Application with Ohio National“EasyApp”

Thank you for applying with Ohio National Life Assurance Company for your term life insurance policy. To process your application as quickly and efficiently as possible, we use a streamlined procedure that we call “EasyApp.” Here’s how it works:

Step One: The Telephone Interview

In the next few days, a representative of Ohio National will call you to complete a 15-20 minute interview. To make this step go as efficiently as possible, please have the following information available:

- Your driver’s license number
- The name, address and telephone number of your physicians
- The name and dosage of any medications you are taking

At the completion of the interview, our representative will ask you to schedule a paramedical exam.

Step Two: The Paramedical Exam

During the exam appointment, the following will occur:

- A blood and urine sample will be taken.
- Your blood pressure, pulse, height and weight will be recorded.
- An EKG may be performed (based upon your age and the amount of life insurance for which you are applying).
- You will be asked to sign documents confirming the information recorded during your interview and exam. Please carefully review each of these documents and record any necessary changes.

Step Three: What Happens Next

After Ohio National receives the results of the interview and the paramedical exam, our underwriting team will review the information. Your representative will then contact you with the company’s underwriting decision.

Please be assured the information you provide at each stage of the application process – both the telephone interview and the paramedical exam – is kept in the strictest confidence at all times.

If you have any questions, comments or concerns about any part of the process, please contact your representative.



The Ohio National Life Insurance Company

Ohio National Life Assurance Corporation

Please detach
and deliver to
proposed insured
immediately.

P.O. Box 5409
Cincinnati, Ohio 45201-5409
(513) 794-6100

Notice of Information Practices

One of the prime objectives of Ohio National is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure low cost, but also to assure that the fair share of the cost is contributed by each policyholder. Information from a number of sources is considered when we evaluate your application. We consider the results of your physical examination, if required, and any reports Ohio National may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Ohio National or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

When authorized by you, Ohio National or its reinsurers may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Furthermore, as part of the processing of your insurance application, we may request an investigative consumer report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your desire. You also have the right to receive a copy of the report and, by making a written request to Ohio National within a reasonable period of time, to receive additional, detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to ask about personal information which we may have in our files and the right to seek a correction of information you think is wrong.

Ask our agent for assistance, or write or call us at Ohio National, Attention: Underwriting Division, P.O. Box 5409, Cincinnati, Ohio 45201-5409. Telephone (513) 794-6100.

Thank you for your application.



Authorization For Release Of Personal Health Information

This authorization is designed to comply with the HIPAA Privacy Rule.

I hereby authorize any health plan, health care provider or health care clearinghouse that has provided payment, treatment or services to the Patient or on his or her behalf to release to the persons or entities identified in Paragraph Number 1 information it has about the Patient's physical or mental health. Paragraph Number 2 describes the class of persons or entities hereby authorized to release personal health information about the Patient. These persons or entities may disclose the information described in paragraph Number 3.

Proposed Insured (Patient's Name)

Date of Birth

Social Security Number

Additional Insured (Patient's Name)

Date of Birth

Social Security Number

1. The records and information will be disclosed to **The Ohio National Life Insurance Company or Ohio National Life Assurance Corporation**, (Ohio National) P.O. Box 237, Cincinnati, Ohio 45201 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about the Patient:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. [MIB]) or other health care provider, the Veterans Administration; a consumer reporting agency and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of the Patient's **entire medical record** and any other protected health information concerning the Patient including, without limitation, office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to the Patient. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. You may also disclose any financial, employment or personal information requested for insurance purposes.

The purpose of this disclosure is to evaluate an application for insurance or claim for benefits.

Ohio National may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim thereunder; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This authorization is good, as needed, for 24 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I have received Ohio National's Notice of Information Practices.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to Ohio National. Actions taken in reliance of this Authorization will not be affected, but no further actions will be taken in reliance of this Authorization after revocation is received by Ohio National. Revocation of this Authorization may result in the refusal to offer insurance coverage or pay benefits under a policy that has been issued.

Signature of Patient (Proposed Insured)

Date

If signed on behalf of Patient (Proposed Insured), the signer is the Patient's:

Parent/Guardian of minor

Other (specify) _____

Signature of Patient (Proposed Additional Insured)

Date

If signed on behalf of Patient (Proposed Additional Insured), the signer is the Patient's:

Parent/Guardian of minor

Other (specify) _____

Authorization For Release Of Personal Health Information

This authorization is designed to comply with the HIPAA Privacy Rule.

I hereby authorize any health plan, health care provider or health care clearinghouse that has provided payment, treatment or services to the Patient or on his or her behalf to release to the persons or entities identified in Paragraph Number 1 information it has about the Patient's physical or mental health. Paragraph Number 2 describes the class of persons or entities hereby authorized to release personal health information about the Patient. These persons or entities may disclose the information described in paragraph Number 3.

Proposed Insured (Patient's Name)

Date of Birth

Social Security Number

Additional Insured (Patient's Name)

Date of Birth

Social Security Number

1. The records and information will be disclosed to **The Ohio National Life Insurance Company or Ohio National Life Assurance Corporation**, (Ohio National) P.O. Box 237, Cincinnati, Ohio 45201 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about the Patient:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. [MIB]) or other health care provider, the Veterans Administration; a consumer reporting agency and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of the Patient's **entire medical record** and any other protected health information concerning the Patient including, without limitation, office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to the Patient. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. You may also disclose any financial, employment or personal information requested for insurance purposes.

The purpose of this disclosure is to evaluate an application for insurance or claim for benefits.

Ohio National may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim thereunder; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This authorization is good, as needed, for 24 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I have received Ohio National's Notice of Information Practices.
- I acknowledge that I have read this Authorization and received a copy of it.
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Signature of Patient (Proposed Insured)

Date

Signature of Patient (Proposed Additional Insured)

Date

If signed on behalf of Patient (Proposed Insured), the signer is the Patient's:

- Parent/Guardian of minor
 Other (specify) _____

If signed on behalf of Patient (Proposed Additional Insured), the signer is the Patient's:

- Parent/Guardian of minor
 Other (specify) _____

EasyApp (Life Insurance Application)

1. Proposed Insured Information

a. First Name Middle Name (no initials, please) Last Name

b. Home Address How long at this address?

City County State Zip

c. Mailing Address (if different than home) City State Zip

d. Birth Date e. Issue Age (nearest birthday) f. State or Country of Birth

g. Social Security Number h. Male Female

i. Are you a U.S. citizen or permanent U.S. resident? Yes No If "No," what country?

If "No," how long in the United States?

j. Telephone Numbers Home Work Other

2. Owner Information (Complete only if policy is to be owned by other than the Proposed Insured.)

Unless otherwise indicated, if two or more persons are designated in any one category, their interests shall be joint and survivor.

a. Owner's Name (if other than insured) Relationship to Insured

Owner's Address City State Zip

Owner's Social Security Number

If owner is a trust, list full name, date of trust and trustee's name.

NOTE: If above Owner dies before the Insured, ownership passes to the deceased Owner's estate. Fill out the Contingent Owner designation if such result is not desired.

b. Contingent Owner Name Relationship to Insured

3. Beneficiary Information

Unless otherwise indicated, "Children" shall mean the lawful children of the Insured by birth or adoption.

a. Primary Beneficiary(ies) and Percentage Relationship to Insured

b. Contingent Beneficiary(ies) and Percentage Relationship to Insured

If beneficiary is a trust, list full name and date of trust and trustee's name.

4. Life Plans

- a. Plan of Insurance 10 10 Plus 15 15 Plus 20 20 Plus Recap Other
- b. Face Amount
- c. Premium Mode A S Q Monthly Bank Draft List Bill
- d. Is employer paying the premium? Yes No

5. Life Riders/Benefits

- | | |
|---|---|
| <p>a. <input type="checkbox"/> Children's Rider Amount
\$ <input type="text"/></p> <p>b. <input type="checkbox"/> Other Riders and Benefits:
<input type="text"/>
<input type="text"/></p> | <p>c. <input type="checkbox"/> Waiver of Premium Amount
\$ <input type="text"/></p> <p>d. <input type="checkbox"/> Accidental Death Benefit \$ <input type="text"/></p> <p>e. <input type="checkbox"/> Lifetime Advantage Rider
(If selected, complete Form 2946)</p> |
|---|---|

6. Additional Insureds

Full Name	Relationship	Sex	Age	Birthdate	State of Birth	Height	Weight	Amount Ins. in Force

7. Premium Information/Temporary Insurance Coverage

- a. Has any person proposed for coverage been diagnosed or treated for heart attack, stroke or cancer within the last two years; or been advised to have any surgery which has not been performed? Yes No
If 7a is answered "Yes" or if the amount applied for exceeds \$1 million or over age 65, no money may be accepted, and 7b must be answered "No."
- b. Is premium submitted with the application? Yes No Amount remitted \$

8. Other Coverage/Replacement Information

- a. Do you have or are you applying for other life insurance? Yes No
- b. Will proposed policy replace or cause change in any existing policy? Yes No

If either 8a or 8b is answered "Yes," list all types of insurance below, and indicate whether the proposed policy will replace or cause change in any existing policy. (For ID & SC residents: Include all annuities.)

Company or Source	Type of Insurance	Face Amount of Insurance	Will It Be Replaced?	Replacement Date
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Mutual Agreements

It is mutually agreed that:

- The statements and answers on this application are true and complete to the best of my knowledge and belief. A copy of this application will be the basis of any policy issued.
- By signing below, I acknowledge receipt of the Limited Temporary Insurance Agreement given in exchange for my payment shown in Question 7 of this application; and I accept the terms and conditions of that Agreement.
- Except as provided in my Temporary Insurance Agreement, no policy shall be in force unless and until: (1) it is delivered to me; (2) the full first premium is paid during the lifetime of all persons to be insured under the policy; and (3) the statements and answers in this application remain true and

Month _____ Day _____ Year _____

City _____ State _____

I hereby certify that I have truly and accurately recorded on this application the information supplied by the Applicant and/or Proposed Insured.

Will this contract change or replace any existing life insurance policy or an annuity of this or any other company? Yes No

Signature of Agent

complete, without material change, as of the date of the policy delivery.

- By accepting an insurance policy issued on this application, I ratify any corrections, additions or changes made by Ohio National and noted in the Home Office Endorsements section. In those states where required, there can be no change in amount, age at issue, risk class, plan of insurance, or benefits, unless I agree to the change in writing.
- No agent is authorized to make or change a contract of insurance for Ohio National, nor extend the due date for a premium payment, nor waive any of Ohio National's rights or requirements.

Signature of Proposed Insured

Signature of Spouse or Additional Insured

Signature of Owner/Applicant (When Applicant is other than Proposed Insured, (or one authorized to sign for the Applicant)

(Agent) City

State

Authorization

AUTHORIZATION to any physician; practitioner; hospital, clinic or other medical or medically related facility; health care provider; insurance company or reinsurance company; insurance support organization; the Veterans Administration; the Medical Information Bureau, Inc. (MIB); a consumer reporting agency; motor vehicle records facility and/or employer:

In order to enable Ohio National Life to act upon my application for insurance or to decide if I qualify for benefits or coverage, I authorize you to give to Ohio National Life any and all information, records or knowledge which you have about my physical or mental condition. This authorization covers medical history, evaluation, tests, diagnosis, treatment or prognosis, and includes information about drugs, alcoholism or mental illness. You may also give Ohio National Life any financial, employment or personal information requested for insurance purposes.

Ohio National Life may release information to reinsurance companies, to MIB, Inc., or to others who perform business or legal services related to my application or the policy or claim thereunder. Information will not be released to anyone else unless required or permitted by law or unless further authorized by me.

Date

- This authorization is good, as needed, for 24 months from the date signed or while I have a claim, if longer.
- I agree that a photocopy of this authorization may be used the same as the original.
- I have received the Notice of Information Practices.
- I understand that I have the right to receive a copy of this authorization.

If signing for someone, also check here and identify below.

Parent/Guardian of minor(s)

Spouse/Representative of the Deceased Insured

Other (specify) _____

Identify married woman's maiden name, names of minor children, Insured's name, or others to whom authorization applies.

Signature of Proposed Insured

Signature of Spouse or Additional Insured

Temporary Life Insurance Agreement

TEMPORARY LIFE INSURANCE IS NOT AVAILABLE UNDER ANY CIRCUMSTANCES IF THE APPLICATION IS FOR MORE THAN \$1,000,000 OF LIFE INSURANCE WITH OHIO NATIONAL LIFE. YOU MUST BE INSURABLE.

When Insurance Begins: Subject to all terms and conditions of this Agreement, you will have life insurance for not more than **60** days beginning when, and if, all of the following conditions are met:

1. you are less than age 70; and
2. you have not been diagnosed or treated for heart attack, stroke or cancer within the last two years; and
3. you have not been advised to have any surgery which has not been performed; and
4. you have truthfully completed and signed the Application for life insurance with Ohio National Life; and
5. you have taken all medical or paramedical exams and tests we require under our underwriting guidelines and practices, which may include an x-ray and an electrocardiogram (EKG); and
6. the first monthly premium for the policy as applied for has been paid to Ohio National Life by a means acceptable to us.

Terms

NO AGENT OR BROKER HAS THE AUTHORITY TO APPROVE OR EXTEND TEMPORARY LIFE INSURANCE OR WAIVE OR CHANGE ANY TERM OR CONDITION OF THIS AGREEMENT. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO "OHIO NATIONAL LIFE". DO NOT MAKE YOUR CHECK PAYABLE TO THE AGENT OR LEAVE "THE PAYEE" BLANK.

Exclusions: No life insurance under this Agreement is available:

1. under any rider for which the Applicant has applied; or
2. if death results from suicide or self-destruction; or
3. if death is proximately caused by a sickness, injury or condition for which a medical professional provided or prescribed treatment within one year prior to the date of the Application; or
4. if we find that you were not insurable as of the effective date of this Agreement under our underwriting guidelines and practices.

Amount of Insurance: The amount of life insurance provided by this Agreement is the **Smallest** of: (a) the amount applied for in the Application; or (b) the amount we will issue based on your income and assets according to our guidelines and practices; or (c) \$1,000,000 minus the amount of all other life insurance coverage on you with Ohio National Life.

When Insurance Ends: Life insurance under this Agreement ends on the **Earliest** of (a) 60 days after it begins, (b) the date the insurance policy applied for takes effect; (c) the date we offer a policy other than as applied for; (d) the date we decline, postpone or make incomplete the Application and mail notice of that decision to the Applicant and refund the premium payment; or (e) the date we mail the Applicant notice that coverage ends and refund the premium payment. We may end your coverage under this Agreement and refund the premium payment at any time.

Death of Proposed Insured: If you die while this Agreement is in effect we will pay the death proceeds in accordance with the beneficiary designation in the Application unless one of the Exclusions listed

above applies. If we pay a claim under this Agreement, we will retain from the proceeds one month's premium for the amount of the claim at the rate for your sex and age at a standard smoker or standard non-smoker risk class based on our findings about your use of tobacco.

Changes in the Proposed insured's Health: This Agreement does not commit us to issue the policy applied for or any other policy. However, if we can find, based on our underwriting guidelines and practices, that you were a standard risk or better for life insurance as of the date your coverage began under this Agreement, then: (a) we will deliver the policy as approved without regard to any change in your health which occurs while this Agreement is in effect; and (b) we will offer you policy coverage in place of this Agreement to take effect the same date as insurance began under this Agreement. Any policy we offer may be different from the one for which you applied. It may be reduced in amount according to our guidelines and practices. If your health has changed, no life insurance policy will be issued for more than the amount of your temporary coverage under this Agreement.

Premiums; Refunds: The payment made to us with this Temporary Life Insurance Agreement will be applied to pay premiums due under any policy we issue to you. If no policy takes effect, and no claim is incurred, our only obligation is to refund your money. All refunds are without interest.

Definitions: The Application to which this Agreement relates includes the health questions you answered as part of any required medical or paramedical exam. "You" or "your" means the Proposed Insured, as identified on the Application and below. "We", "our", "us" or "Ohio National Life" means The Ohio National Life Insurance Company and Ohio National Life Assurance Corporation, One Financial Way, Cincinnati, Ohio 45242.

Proposed Insured

Date of Application (Part-1)

Receipt

We acknowledge receipt of your payment as shown below.

Amount Received

Date

Signature of Agent

\$

Temporary Life Insurance Agreement

TEMPORARY LIFE INSURANCE IS NOT AVAILABLE UNDER ANY CIRCUMSTANCES IF THE APPLICATION IS FOR MORE THAN \$1,000,000 OF LIFE INSURANCE WITH OHIO NATIONAL LIFE. YOU MUST BE INSURABLE.

When Insurance Begins: Subject to all terms and conditions of this Agreement, you will have life insurance for not more than **60** days beginning when, and if, all of the following conditions are met:

1. you are less than age 70; and
2. you have not been diagnosed or treated for heart attack, stroke or cancer within the last two years; and
3. you have not been advised to have any surgery which has not been performed; and
4. you have truthfully completed and signed the Application for life insurance with Ohio National Life; and
5. you have taken all medical or paramedical exams and tests we require under our underwriting guidelines and practices, which may include an x-ray and an electrocardiogram (EKG); and
6. the first monthly premium for the policy as applied for has been paid to Ohio National Life by a means acceptable to us.

Terms

NO AGENT OR BROKER HAS THE AUTHORITY TO APPROVE OR EXTEND TEMPORARY LIFE INSURANCE OR WAIVE OR CHANGE ANY TERM OR CONDITION OF THIS AGREEMENT. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO "OHIO NATIONAL LIFE". DO NOT MAKE YOUR CHECK PAYABLE TO THE AGENT OR LEAVE "THE PAYEE" BLANK.

Exclusions: No life insurance under this Agreement is available:

1. under any rider for which the Applicant has applied; or
2. if death results from suicide or self-destruction; or
3. if death is proximately caused by a sickness, injury or condition for which a medical professional provided or prescribed treatment within one year prior to the date of the Application; or
4. if we find that you were not insurable as of the effective date of this Agreement under our underwriting guidelines and practices.

Amount of Insurance: The amount of life insurance provided by this Agreement is the **Smallest** of: (a) the amount applied for in the Application; or (b) the amount we will issue based on your income and assets according to our guidelines and practices; or (c) \$1,000,000 minus the amount of all other life insurance coverage on you with Ohio National Life.

When Insurance Ends: Life insurance under this Agreement ends on the **Earliest** of (a) 60 days after it begins, (b) the date the insurance policy applied for takes effect; (c) the date we offer a policy other than as applied for; (d) the date we decline, postpone or make incomplete the Application and mail notice of that decision to the Applicant and refund the premium payment; or (e) the date we mail the Applicant notice that coverage ends and refund the premium payment. We may end your coverage under this Agreement and refund the premium payment at any time.

Death of Proposed Insured: If you die while this Agreement is in effect we will pay the death proceeds in accordance with the beneficiary designation in the Application unless one of the Exclusions listed

above applies. If we pay a claim under this Agreement, we will retain from the proceeds one month's premium for the amount of the claim at the rate for your sex and age at a standard smoker or standard non-smoker risk class based on our findings about your use of tobacco.

Changes in the Proposed insured's Health: This Agreement does not commit us to issue the policy applied for or any other policy. However, if we can find, based on our underwriting guidelines and practices, that you were a standard risk or better for life insurance as of the date your coverage began under this Agreement, then: (a) we will deliver the policy as approved without regard to any change in your health which occurs while this Agreement is in effect; and (b) we will offer you policy coverage in place of this Agreement to take effect the same date as insurance began under this Agreement. Any policy we offer may be different from the one for which you applied. It may be reduced in amount according to our guidelines and practices. If your health has changed, no life insurance policy will be issued for more than the amount of your temporary coverage under this Agreement.

Premiums; Refunds: The payment made to us with this Temporary Life Insurance Agreement will be applied to pay premiums due under any policy we issue to you. If no policy takes effect, and no claim is incurred, our only obligation is to refund your money. All refunds are without interest.

Definitions: The Application to which this Agreement relates includes the health questions you answered as part of any required medical or paramedical exam. "You" or "your" means the Proposed Insured, as identified on the Application and below. "We", "our", "us" or "Ohio National Life" means The Ohio National Life Insurance Company and Ohio National Life Assurance Corporation, One Financial Way, Cincinnati, Ohio 45242.

Proposed Insured

Date of Application (Part-1)

Receipt

We acknowledge receipt of your payment as shown below.

Amount Received

Date

Signature of Agent

\$

Agent's Report

Allocation of Production Credit - Please Print

	Agency or Agent Name(s)	Writing Code	Percent
1st Agency			
2nd Agency			

Rates Quoted

- Super Preferred Preferred Select Nonsmoker Nonsmoker Select Smoker Smoker

Replacements

If this contract changes or replaces any existing life insurance policy or an annuity of this or any other company, please list all policies to be replaced.

Comments/Remarks

Instructions

1. Please fax all pages of completed form along with Replacement form(s) & HIPAA Authorization to: (513) 794-4581.
2. Mail original Paperwork to: Underwriting Department, P. O. Box 5409, Cincinnati, Ohio 45201-5409
3. DO NOT ORDER THE PARAMEDICAL EXAM. This will be arranged upon completion of the interview.

The Ohio National Life Insurance Company

Ohio National Life Assurance Corporation

P.O. Box 237
Cincinnati, Ohio 45201-0237

The Federal Income Tax Law requires Ohio National Life to report the taxable gain on certain distributions from life insurance policies and annuity contracts. In order to facilitate proper reporting, the tax law requires you to provide Ohio National Life, as a potential payor, with your correct taxpayer identification number. If you are an individual, your taxpayer identification number is your Social Security number. Businesses or trusts should provide their employer or trust identification number. Please complete the following information.

1. Enter the owner's taxpayer number in the appropriate space. For individuals, this is the Social Security Number.

For organizations, this is the Employer Identification Number.

2. Owner Name

Address

City

State

Zip

3. **Certification: Under the penalties of perjury, I certify that the information provided on this form is true, correct, and complete. I have not been notified by the I.R.S. that I am subject to withholding for underreporting under Section 3406(a)(1)(c). I am a U.S. person (including a U.S. resident alien).**

Policy/Contract Number

Insured Name

Date

Signature of Owner

Important Tax Information

Failure to provide your correct taxpayer identification number may subject you to penalties and backup withholding on any taxable distribution from your policy or contract. A penalty of \$50 may be assessed by the Internal Revenue Service against any person who fails to provide the correct number to a payor of reportable income. Knowingly or intentionally providing false information on a request for your taxpayer identification number may result in a penalty of \$500. The penalty for falsifying the certification may be a fine and/or imprisonment.

If backup withholding applies, Ohio National must withhold 31% of the interest, certain policy gains and other payments made to you. Backup withholding is not an additional tax. If backup withholding results in an overpayment of tax, you may obtain a refund by filing a tax return.



The Ohio National Life Insurance Company
Ohio National Life Assurance Corporation/Cincinnati

One Financial Way
Cincinnati, Ohio 45242
Telephone: 1-800-366-6654

Policy Number: _____ **Name:** _____

Authorization Agreement For Direct Payments (ACH Debits)

(Initial to Elect) _____ **Single Debit for Initial Premium**

I request and authorize Ohio National Life to initiate a single debit from my bank account (listed below) for the purpose of either (a) collecting the initial premium for the life insurance policy for which I am applying, or (b) collecting any premium in addition to that submitted with my application necessary to put the insurance into effect. I understand and agree that the debit will be made after approval of my application for life insurance through and in accordance with the rules of the Automated Clearing House (ACH) and with US law. Ohio National Life will give me advance notice of the amount and date of the debit by the means selected below and then confirm those to me in writing. If the debit is not honored by my financial institution, no insurance will go into effect. I may revoke this authorization by calling or writing to Ohio National Life prior to the date it initiates the debit.

Please notify me of the date and the amount of the single debit via the following:

E-Mail (not encrypted) at: _____

Telephone at: _____

I understand and agree that by granting this authorization for a single debit of the initial premium that no life insurance will be in effect until my application has been approved, the initial premium is paid and the policy has been delivered to me in accordance with the terms of application.

(Initial to Elect) _____ **Regular Monthly Debits for Recurring Premiums**

I request and authorize Ohio National Life to initiate monthly debits from my bank account for the purpose of collecting premiums and/or reducing a policy loan balance for the listed policy(ies). I understand and agree that the debits will be made through and in accordance with the rules of the Automated Clearing House (ACH) and with US law. Ohio National Life will notify me in writing as to the date and amount of the initial debit. Debits will continue thereafter on a monthly basis while the policy or policies remain in force or, if the debits are to reduce a loan balance, until the policy loan has been repaid in full. Debits for premium payments or loan reduction for any policy will terminate when the policy lapses, is surrendered, matures or when Ohio National Life receives notice of the insured's death. I may revoke this authorization at any time by calling or writing Ohio National Life. Debits will be terminated on the next scheduled debit date that is at least ten days after Ohio National receives my notice to terminate the debit.

During the continuation of this Authorization, Ohio National Life will not give notice of premiums due. Ohio National Life will give me notice in writing at least ten days prior to any change in the debit amount. The option of applying dividends to reduce premiums will not be available, except for disability income policies.

I understand that if a debit is not honored by my financial institution or if I revoke this Authorization the policy may lapse at the end of the grace period, the elected non-forfeiture option may be exercised or an automatic policy loan may be taken for the amount of the premium due. Ohio National may terminate future debits and this authorization immediately if any debit is not honored by the bank or financial institution that holds my account.

Bank/Financial Institution _____ Routing Number _____ Account Number _____

Type of Account: Checking Savings Money Market ***Attach voided check for this account.***

Add to existing ACH Debit Preferred Monthly Draft Day: _____

Existing Policy Number(s): _____

Name of Insured(s) on Existing: _____

Signature/Bank Account Owner

Date