Fondo de Seguros de Vida del Estado

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873 • Madison, WI 53707-7873 • (608) 266-0107 ó 1-800-562-5558
oci.wi.gov/slif.htm

HISTORIA DEL FONDO

El State Life Insurance Fund (el Fondo) es un programa de seguros de vida patrocinado por el estado en beneficio de los residentes de Wisconsin.

El Fondo es una organización sin fines de lucro que no recibe subsidios del estado. El uso de agentes que trabajan por comisión está prohibido, no publicita y está exenta de pagar el impuesto a la renta federal. Como resultado, los gastos de estructura son mínimos.

El Fondo se estableció en 1911 como respuesta a un escándalo nacional relacionado con prácticas inapropiadas por parte de algunas empresas de seguros de vida.

De acuerdo con el Comisionado de Seguros de ese momento, el Fondo se estableció "...para darle a la gente del estado el beneficio de gozar del mejor seguro de la vieja línea por medio de un plan mutual con el costo más bajo posible".

Originalmente, el nivel máximo de cobertura disponible para cada asegurado era de $1,000. Ahora el máximo es de $10,000.

TIPOS DE PÓLIZAS DE SEGUROS DE VIDA

El Fondo paga dividendos a todos los seguros de vida que emite. Los dos tipos son:

SEGURO A PLAZO

El Fondo ofrece una póliza a plazo hasta los 65 años. Las primas para estas pólizas se mantienen iguales hasta que la póliza finalice. El seguro a plazo hasta los 65 años puede convertirse a cualquier tipo de seguro de vida total antes de los 55 años (el Fondo no ofrece pólizas a plazo que disminuyan o que sean renovables anualmente).

El seguro a plazo brinda protección en caso de fallecimiento durante un período específico. Los beneficios por fallecimiento solamente se pagarán si usted muere dentro de ese período. Por lo general, la gente adquiere los seguros a plazo para obtener la mayor protección por su dinero en caso de fallecimiento.

SEGURO DE VIDA TOTAL

El Fondo ofrece cuatro tipos diferentes de pólizas de vida total. La póliza de vida común posee primas que se pagan durante la vida del asegurado. La póliza de vida que se paga hasta los 65 años posee primas que solamente se pagan hasta los 65 años. La póliza de vida de 20 pagos se paga durante 20 años. La póliza de vida con prima única posee una sola prima que se abona en el momento de la emisión.

El seguro de vida total brinda protección de seguro durante toda la vida del asegurado, siempre que se pague la prima.

Las pólizas de vida total acumulan valor en efectivo que se le devuelve si usted rescinde la póliza. Puede pedir un préstamo por el valor en efectivo de la póliza. Si lo hace, el valor neto de la póliza se reducirá proporcionalmente.

El seguro de vida total a veces se adquiere como una forma de inversión. Sin embargo, un monto muy pequeño de su prima se le devolverá si rescinde su póliza en los primeros años. Durante los primeros años, el índice de devolución del valor en efectivo es bajo. No debe considerar la adquisición de una póliza de vida total como una inversión, salvo que quiera mantenerla por veinte años o más.

PROCESO DE SOLICITUD

ELEGIBILIDAD

Las pólizas de seguros de vida solamente están disponibles para las personas que residen en el estado de Wisconsin en el momento en que se presenta la solicitud. Los asegurados propuestos deben tener por lo menos 14 días de vida.

Los cinco tipos diferentes de pólizas están disponibles para los residentes que representan un riesgo normal. Los residentes que representan un riesgo por debajo de lo normal solamente pueden solicitar una póliza de vida común.

La evaluación de riesgo de las solicitudes de aquellos que representan riesgos por debajo de lo común puede requerir que el Fondo busque información en la Medical Information Bureau o que se realice un informe del consumidor. Esta información solo se podrá obtener si es necesario.

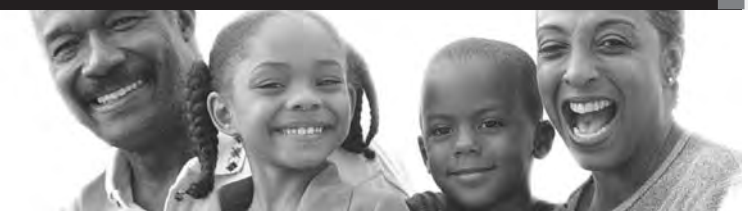
No es obligación del Fondo proporcionar seguros a todos los residentes que lo solicitan. Por lo tanto, algunas personas que presenten riesgos que se encuentren por debajo de lo normal pueden no ser elegibles para el seguro por parte del Fondo. El Fondo debe operar de manera consistente con los asegurados privados en cuanto a la cobertura de la póliza, los exámenes médicos y los procedimientos de evaluación de riesgos.

EXÁMENES MÉDICOS

El Fondo exige la realización de un examen médico a los solicitantes que tengan 45 años de edad o más. El Fondo puede exigir la realización de exámenes a otros solicitantes. Si se exige o se solicita la realización de un examen médico, el solicitante deberá visitar a un médico matriculado. El Fondo pagará un monto fijo para la realización del examen.

Para solicitar asistencia en español comuníquese al: 608/266-3586

OCI 42-572 (R 12/2015)



COSTOS DEL SEGURO DE VIDA

CUADRO DE PRIMAS

Las primas para las pólizas estándares ofrecidas por el Fondo aparecen en la próxima página. Para determinar su prima, busque su edad, el sexo y la póliza que desee adquirir. Las tasas indican el costo por $1,000 de seguro. Multiplique esta tasa por el monto del seguro que usted desee adquirir para determinar la prima real que pagará. Si paga trimestral o semestralmente, los costos serán más altos. Si puede pagar las primas anualmente, ahorrará este costo.

BENEFICIO DE SUSPENSIÓN DE LA PRIMA

El beneficio de suspensión de la prima se aplica automáticamente a las personas que representan riesgos comunes y que adquieren un seguro de vida a través del Fondo. Esto quiere decir que si el asegurado queda incapacitado total y permanentemente, el Fondo realiza los pagos de las primas por medio de los beneficios y la póliza permanece vigente.

Este beneficio vence cuando el asegurado alcanza los 60 años de edad, salvo que el asegurado esté incapacitado en ese momento.

VALOR EN EFECTIVO POR RESCISIÓN

El valor en efectivo por la rescisión es el monto de dinero garantizado en la póliza. Los valores en efectivo por rescisión son importantes para los asegurados que desean pedir prestado dinero o construir un fondo de bienes.

Los valores en efectivo por rescisión pueden pedirse prestados. Si usted pide prestado el valor en efectivo por rescisión y muere, este monto se deducirá de los beneficios pagados. Actualmente, el Fondo aplica un 8% de interés en los préstamos pendientes. Si decide rescindir la póliza, recibirá el valor en efectivo neto por rescisión. Si desea obtener un listado impreso de los valores en efectivo para un plan en especial, comuníquese con el Fondo.

OTRAS CONSIDERACIONES

El costo es solo uno de los temas a considerar cuando se adquiere un seguro de vida. Los consumidores también deben preocuparse por las cláusulas del contrato de la póliza, la estabilidad del asegurador y los servicios que se reciben.

INSTRUCCIONES PARA LA SOLICITUD

Las instrucciones para completar el formulario de solicitud del Fondo están incluidas en el formulario. Sin embargo, debe tener en cuenta cinco instrucciones importantes:

1. Debe responder todas las preguntas que aparecen en la solicitud. El procesamiento del seguro se retrasará si hay respuestas incompletas.
2. Debe ingresar la prima anual total en la solicitud. Para una póliza de $5,000, la prima anual será cinco veces la tasa por $1,000, etc. Debe colocar esto en el formulario de solicitud aunque esté pagando trimestral o semestralmente.
3. Complete con el nombre completo de todos los beneficiarios. No ingrese el nombre de los beneficiarios como “mi esposa”, “mi cónyuge” o “Señora Brown”.
4. Si la persona cubierta por el seguro es menor de 16 años, se debe designar a una persona responsable.
5. Envíe el formulario de solicitud y la prima a State Life Insurance Fund, P.O. Box 7873, Madison, WI 53707–7873.

Para solicitar asistencia en español comuníquese al: 608/266-3586

PRE NOTICE—
DISCLOSURE OF INFORMATION

State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or 1-800-562-5558
Fax: (608) 264-6220
ocislif@wisconsin.gov
oci.wi.gov/Pages/Funds/SLIFOverview.aspx

We, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc., is a not-for-profit membership organization of insurance companies that 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 the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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 telephone number is 866-692-6901. Information for consumers about MIB, Inc., may be obtained on its Web site at www.mib.com.

LIFE INSURANCE ANNUAL PREMIUMS PER $1,000

INCLUDES WAIVER OF PREMIUM BENEFIT AT APPLICABLE AGES
MALE PREMIUMS

Issue Age	OL Ordinary Life	20P Twenty Pay Life	L65 Life Paid Up at Age 65	T65 Term to Age 65	SP Single Premium Life
0	8.26	10.68	8.39	N/A	120.67
1	8.37	10.85	8.50	N/A	123.07
2	8.47	11.03	8.62	N/A	125.65
3	8.57	11.21	8.73	N/A	128.30
4	8.67	11.39	8.84	N/A	131.00
5	8.77	11.57	8.95	N/A	133.76
6	8.89	11.79	9.10	N/A	136.78
7	9.02	12.01	9.24	N/A	139.86
8	9.15	12.22	9.39	N/A	143.01
9	9.27	12.44	9.53	N/A	146.22
10	9.39	12.67	9.67	N/A	149.48
11	9.56	12.93	9.86	N/A	153.10
12	9.72	13.20	10.05	N/A	156.77
13	9.88	13.46	10.24	N/A	160.49
14	10.03	13.71	10.42	N/A	164.22
15	10.17	13.96	10.59	7.19	167.92
16	10.35	14.24	10.81	7.26	171.95
17	10.52	14.51	11.02	7.30	175.90
18	10.70	14.78	11.24	7.34	179.74
19	10.87	15.05	11.45	7.37	183.65
20	11.04	15.32	11.67	7.40	187.63
21	11.25	15.63	11.93	7.45	191.99
22	11.46	15.94	12.20	7.50	196.44
23	11.67	16.25	12.48	7.54	200.98
24	11.88	16.57	12.76	7.58	205.63
25	12.10	16.89	13.06	7.63	210.37
26	12.36	17.26	13.41	7.69	215.56
27	12.63	17.64	13.77	7.76	220.91
28	12.91	18.03	14.16	7.83	226.43
29	13.21	18.43	14.56	7.91	232.14
30	13.50	18.84	14.99	7.99	238.02
31	13.86	19.31	15.49	8.11	244.33
32	14.23	19.78	16.01	8.22	250.79
33	14.60	20.26	16.56	8.32	257.37
34	14.98	20.75	17.14	8.43	264.10
35	15.38	21.24	17.75	8.52	270.95
36	15.84	21.80	18.45	8.65	278.15
37	16.31	22.37	19.19	8.76	285.47
38	16.80	22.94	19.97	8.87	292.90
39	17.31	23.53	20.81	8.97	300.46
40	17.83	24.12	21.71	9.06	308.15
41	18.34	24.74	22.67	9.18	316.04
42	18.88	25.38	23.70	9.30	324.09
43	19.44	26.04	24.83	9.42	332.31
44	20.02	26.72	26.07	9.56	340.78
45	20.64	27.44	27.44	9.71	349.49
46	21.29	28.15	28.95	9.85	358.45
47	21.97	28.89	30.64	10.00	367.68
48	22.69	29.67	32.52	10.18	377.17
49	23.45	30.48	34.63	10.37	386.95
50	24.25	31.32	37.01	10.58	397.00
51	25.07	32.13	39.67	10.88	407.39
52	25.93	32.97	42.74	11.21	418.03
53	26.83	33.84	46.29	11.56	428.90
54	27.78	34.75	50.46	11.93	440.00
55	28.77	35.70	55.43	12.33	451.33
56	29.68	36.46	N/A	N/A	462.98
57	30.63	37.24	N/A	N/A	474.85
58	31.61	38.05	N/A	N/A	486.90
59	32.64	38.90	N/A	N/A	499.12
60	33.70	39.78	N/A	N/A	511.49
61	35.29	41.18	N/A	N/A	524.22
62	36.97	42.65	N/A	N/A	537.06
63	38.75	44.21	N/A	N/A	550.00
64	40.65	45.87	N/A	N/A	563.01
65	42.67	47.65	N/A	N/A	576.09
66	45.15	49.76	N/A	N/A	589.58
67	47.83	52.06	N/A	N/A	603.18
68	50.73	54.55	N/A	N/A	616.88
69	53.86	57.29	N/A	N/A	630.67
70	57.24	60.28	N/A	N/A	644.51
71	N/A	N/A	N/A	N/A	659.39
72	N/A	N/A	N/A	N/A	674.26
73	N/A	N/A	N/A	N/A	689.05
74	N/A	N/A	N/A	N/A	703.73
75	N/A	N/A	N/A	N/A	718.26
76	N/A	N/A	N/A	N/A	733.92
77	N/A	N/A	N/A	N/A	749.50
78	N/A	N/A	N/A	N/A	765.00
79	N/A	N/A	N/A	N/A	780.42
80	N/A	N/A	N/A	N/A	795.73

INCLUDES WAIVER OF PREMIUM BENEFIT AT APPLICABLE AGES
FEMALE PREMIUMS

Issue Age	OL Ordinary Life	20P Twenty Pay Life	L65 Life Paid Up at Age 65	T65 Term to Age 65	SP Single Premium Life
0	7.89	9.99	8.01	N/A	110.58
1	7.98	10.15	8.11	N/A	112.61
2	8.07	10.30	8.21	N/A	114.86
3	8.16	10.47	8.31	N/A	117.22
4	8.25	10.62	8.41	N/A	119.62
5	8.33	10.78	8.51	N/A	122.06
6	8.45	10.97	8.64	N/A	124.74
7	8.56	11.16	8.77	N/A	127.46
8	8.67	11.36	8.90	N/A	130.25
9	8.78	11.55	9.02	N/A	133.08
10	8.89	11.74	9.15	N/A	135.96
11	9.03	11.97	9.31	N/A	139.14
12	9.17	12.21	9.48	N/A	142.38
13	9.32	12.44	9.65	N/A	145.71
14	9.45	12.67	9.81	N/A	149.08
15	9.58	12.89	9.97	6.66	152.44
16	9.74	13.15	10.17	6.70	156.12
17	9.90	13.40	10.37	6.73	159.80
18	10.06	13.66	10.57	6.76	163.53
19	10.23	13.92	10.77	6.80	167.35
20	10.39	14.19	10.98	6.83	171.27
21	10.59	14.49	11.24	6.88	175.53
22	10.79	14.80	11.50	6.94	179.91
23	11.00	15.11	11.76	6.98	184.39
24	11.20	15.42	12.03	7.02	188.94
25	11.41	15.73	12.31	7.05	193.57
26	11.66	16.09	12.65	7.11	198.61
27	11.91	16.45	12.99	7.18	203.77
28	12.17	16.83	13.35	7.24	209.07
29	12.43	17.20	13.73	7.30	214.49
30	12.70	17.59	14.12	7.35	220.04
31	13.02	18.01	14.57	7.44	225.96
32	13.34	18.45	15.05	7.52	232.01
33	13.68	18.90	15.55	7.60	238.20
34	14.02	19.35	16.08	7.67	244.53
35	14.37	19.81	16.63	7.73	250.96
36	14.77	20.32	17.27	7.82	257.74
37	15.20	20.84	17.95	7.89	264.65
38	15.63	21.37	18.67	7.96	271.68
39	16.07	21.92	19.44	8.03	278.84
40	16.54	22.48	20.27	8.09	286.17
41	17.01	23.08	21.17	8.18	293.86
42	17.51	23.70	22.16	8.27	301.76
43	18.02	24.34	23.23	8.36	309.87
44	18.56	25.00	24.40	8.47	318.20
45	19.12	25.68	25.69	8.57	326.75
46	19.73	26.39	27.13	8.74	335.67
47	20.36	27.11	28.72	8.91	344.79
48	21.02	27.85	30.49	9.08	354.12
49	21.71	28.62	32.47	9.26	363.65
50	22.42	29.42	34.70	9.44	373.39
51	23.16	30.18	37.24	9.72	383.49
52	23.93	30.97	40.16	10.01	393.82
53	24.74	31.79	43.54	10.31	404.35
54	25.58	32.63	47.51	10.63	415.08
55	26.46	33.50	52.24	10.97	426.02
56	27.26	34.20	N/A	N/A	437.34
57	28.09	34.91	N/A	N/A	448.85
58	28.96	35.65	N/A	N/A	460.56
59	29.85	36.41	N/A	N/A	472.45
60	30.78	37.20	N/A	N/A	484.52
61	32.09	38.35	N/A	N/A	496.89
62	33.47	39.56	N/A	N/A	509.41
63	34.93	40.83	N/A	N/A	522.06
64	36.48	42.17	N/A	N/A	534.83
65	38.11	43.60	N/A	N/A	547.69
66	40.24	45.42	N/A	N/A	560.88
67	42.52	47.38	N/A	N/A	574.14
68	44.96	49.48	N/A	N/A	587.46
69	47.58	51.76	N/A	N/A	600.83
70	50.40	54.23	N/A	N/A	614.23
71	N/A	N/A	N/A	N/A	628.45
72	N/A	N/A	N/A	N/A	642.73
73	N/A	N/A	N/A	N/A	657.05
74	N/A	N/A	N/A	N/A	671.40
75	N/A	N/A	N/A	N/A	685.76
76	N/A	N/A	N/A	N/A	701.37
77	N/A	N/A	N/A	N/A	716.96
78	N/A	N/A	N/A	N/A	732.51
79	N/A	N/A	N/A	N/A	748.00
80	N/A	N/A	N/A	N/A	763.39

APPLICATION FOR INSURANCE

Ref: Ch. 607, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or 1-800-562-5558

For office use only: Cash With Application $_____ Date Received _____ Policy Number _____

INSTRUCTIONS: Print in ink or type all information, sign form, and forward to above address. All questions must be answered. Only Wisconsin residents are eligible to apply for this insurance. The Fund is NOT required to provide insurance to all applicants.

A

1. **Proposed Insured's Name** First Middle Last

2. **Resident Address** Number Street City State Zip Code

3. **Sex** ☐Male ☐Female	4. **Age**	Date of Birth ___/___/___ Month Day Year	5. **State of Birth**	6. **Home Phone**	7. **Business Phone**

8. **Social Security # of Insured**	9. **Occupation**	10. **Employer**

11. **Employer Address** Number Street City State Zip Code

12. Who will be paying for this policy? Name Number Street City State Zip Code

B

1. Complete the amount of coverage and premium for the plan of insurance you desire. Maximum coverage amount is $10,000.

Face Amount of Insurance		Annual Premium	
$_____	Ordinary Life	$_____	Premium Amount
$_____	20-Payment Life	$_____	Premium Amount
$_____	Life Paid Up at Age 65	$_____	Premium Amount
$_____	Term to Age 65	$_____	Premium Amount
$_____	Single Premium Life	$_____	Total Premium

2. How do you wish to pay premium? (Not applicable to Single Premium Life.) If amount is less than $10.00, you MUST pay annually.
   ☐ Annually ☐ Semiannually (Annual x .51)
   ☐ Quarterly (Annual x .26)

3. Amount of premium enclosed $_____
   Premium method may be changed only on the policy anniversary date. The Automatic Premium Loan provision is effective on all Fund policies.

4. Dividends are to be:
   ☐ Applied to reduce premium ☐ Left to accumulate interest
   ☐ Paid in cash
   Unless otherwise specified, dividends will be applied to reduce the premium.

C

A minor (under age 16) may not be the owner.

1. **Policy Owner** First Name Middle Initial Last Name

   Address City State Zip Code

   Relationship to Insured Date of Birth

   Social Security # of Owner

2. **Contingent Owner** First Name Middle Initial Last Name

   Relationship to Insured Date of Birth

3. If Proposed Insured is a minor, ownership will pass to the Proposed Insured at:
   ☐ Age 25 ☐ Death of all prior owners ☐ Other _____
   Unless otherwise indicated above, the Proposed Insured shall be the owner of the policy requested by this application. Insured will become owner at Death of all prior owners unless noted above.

D

The beneficiary stated below will receive the policy proceeds upon the insured's death.

1. Who do you wish to name as **Beneficiary**?

   First Name Middle Initial Last Name

   Relationship to Insured Date of Birth Social Security Number

2. If the Beneficiary does not survive you, who do you wish the policy proceeds payable to as **Contingent Beneficiary**?

   First Name Middle Initial Last Name

   Relationship to Insured Date of Birth Social Security Number

Unless other instructions are given, when more than one First Beneficiary or Contingent Beneficiary is named, all proceeds payable will be shared equally by: the First Beneficiary who survive you, or if none, then those Contingent Beneficiaries who survive you. Should no Beneficiaries survive you, proceeds will be payable to the Owner's Estate.

CONTINUED ON OTHER SIDE

E

	Yes	No
1. Are you now in good health? If "No," explain below.	☐	☐
2. Have you ever applied for life or health insurance which was declined, postponed, or modified in any way? If "Yes," give details below.	☐	☐
3. In the past three years have you engaged in skydiving, parachuting, racing, underwater diving, or any hazardous sport or hobby?	☐	☐
4. Do you use or have you used narcotics or other drugs, **including alcohol**, which may be habit forming? If "Yes," explain	☐	☐
5. Do you have a family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disorder, mental illness or suicide? If "Yes," give details below.	☐	☐
6. Do you smoke cigarettes? If "Yes," state daily usage. Amount Per Day_____	☐	☐
7. Are you a pilot or crew member or do you contemplate participation in aviation other than as a fare-paying passenger?	☐	☐
8. Do you have any policies on your life in the State Life Insurance Fund? (Policy Number_____)	☐	☐
9. Will the State Life Insurance Fund coverage applied for in this application replace any existing life insurance? If "Yes," list policy number and company.	☐	☐

_____
Company Policy Number

Explanations:

F 1. To the best of your knowledge and belief, have you ever had, been treated for, or been told that you have:

	Yes	No
a. Heart trouble, high blood pressure, varicose veins, hemorrhoids, or other disorder of the circulatory system?	☐	☐
b. Diabetes, goiter, or any disorder of the glands?	☐	☐
c. Epilepsy, fainting attacks, mental disorders, or other disorder of the brain or nervous system?	☐	☐
d. Cancer, tumor, syphilis, or tuberculosis?	☐	☐
e. Tested positive for HIV in an FDA-licensed test? (NOTE: Disclosure of a positive test result at an anonymous or alternate test site or home test kits is not required.)	☐	☐
f. Asthma, pleurisy, or other disorder of the respiratory system?	☐	☐
g. Neck or back strain, injury, or hernia?	☐	☐
h. Are you currently taking any type of medication?	☐	☐
i. Ulcer, disorder of stomach, intestines, liver, or gall bladder?	☐	☐
j. Sugar in urine, kidney trouble, or other disorder of the genitourinary tract?	☐	☐
k. Arthritis, rheumatism, or other disorder of the bones, joints, or muscles?	☐	☐
l. Psychiatric, psychological, alcohol, and/or drug treatment?	☐	☐
m. Impairment of sight, speech, hearing, or any disorder of the eye, ear, nose, or throat?	☐	☐
n. Surgical operation performed or been advised to have performed?	☐	☐
o. Medical advice, examination, hospitalization, consultation, or treatment during the past 5 years not previously mentioned?	☐	☐

Give details for each "Yes" response above: [Attach Additional Page(s) as Needed.]	Date Occurred	Duration	Degree of Recovery	Physician's Name and Address for Condition
Question No. Condition				

2. Name of Present Doctor	Clinic Name	Proposed Insured's Height	Proposed Insured's Weight
			lbs.
Street Address	City State Zip Code		Weight One Year Ago lbs.

3. Father of Proposed Insured's Name and Address	Mother of Proposed Insured's Name and Address
If Deceased, Cause of Death and Age at Death	If Deceased, Cause of Death and Age at Death

G **PLEASE READ THESE STATEMENT BEFORE SIGNING**

I hereby declare that all answers and statements in this application are complete and true to the best of my knowledge and belief, and I hereby agree that all answers to such questions together with this agreement shall be attached to and form a part of my policy which is issued hereunder. FURTHER, I AGREE THAT INSURANCE APPLIED FOR HEREIN SHALL NOT BE IN FORCE AND EFFECTIVE UNTIL THE POLICY IS ISSUED DURING MY LIFETIME. The policy shall take effect as of the Policy Date specified by the Fund in the policy.

It is required of all insurers to consider whether the purchase of new life insurance suits the needs and means of applicants. If you are satisfied that in consideration of your present life insurance and income the insurance for which you are applying is suitable for your needs, please read and sign the following statement.

I HAVE CONSIDERED MY PRESENT LIFE INSURANCE COVERAGE AND MY INCOME AND FEEL THAT THE INSURANCE FOR WHICH I AM APPLYING THROUGH THE STATE LIFE INSURANCE FUND OF THE STATE OF WISCONSIN IS SUITABLE FOR ME.

Signature of Proposed Insured

Signature of Parent or Guardian (If Proposed Insured Under Age 16)

Signature of Owner (If Designated in C No. 1)

DATED _____ AT _____, WISCONSIN
MO/DAY/YR CITY

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or 1-800-562-5558
Fax: (608) 264-6220
E-mail: ocislif@wisconsin.gov
Web address: oci.wi.gov/slif.htm

I understand that information obtained by this Authorization will be used by the State Life Insurance Fund of Wisconsin to determine eligibility for insurance or eligibility for benefits under an existing policy. Failure to authorize the release of this information may result in the State Life Insurance Fund's inability to issue or modify a life insurance contract.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, MIB, Inc., organization, institution or person that has pertinent records or knowledge of me, my spouse, or my minor or dependent children's health and health care, to release that information to the State Life Insurance Fund of Wisconsin or its reinsurers any and all such relevant information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any, in any form, including, but not limited to, original, electronic, or photographic copies. The information is being released in connection with an application filed with the State Life Insurance Fund by, or on behalf of, the undersigned applicant. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody of HIV or what the results of this test were, if obtained by an individual. I authorize the State Life Insurance Fund or its reinsurers to make a brief report of my protected health information to MIB.

I further authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, organization, institution that has any health records regarding me, my spouse, or my minor or dependent children, to release any and all such information or records pertaining to drug or alcohol abuse or mental illness diagnosis or treatment to the State Life Insurance Fund.

I understand that I may revoke this Authorization by providing advance written notice of termination to the State Life Insurance Fund. Any information released prior to the receipt of the revocation that were made in reliance upon this Authorization cannot be retrieved nor can persons employed by the State Life Insurance Fund be held responsible or liable for such release when the release was performed in accordance with the Authorization of state law.

I understand that there is a potential for information disclosed pursuant to this Authorization to be redisclosed by the State Life Insurance Fund pursuant to state law or as needed for evaluation [i.e., to my authorized representative(s), providers, insurers, third-party administrators, or as required by law]. Since information may need to be redisclosed, there is a chance that the information re-released by the State Life Insurance Fund might not be protected by the HIPAA Privacy Regulations.

I acknowledge that I will receive a copy of this Authorization to Obtain Medical Information.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signature of Applicant (or parent or guardian of proposed insured)	Date of Birth	Date Signed