I/We understand that this insurance is optional and is not a condition or requirement for approval of my/our loan. My monthly premium will be $__________________ which equates to an annual premium of $__________________.

Mortgage Life Insurance Application

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

☎ **Apply by phone (toll-free): 1-800-720-1728**

FIRST APPLICANT (Please Print)				SECOND APPLICANT (Please Print)			
Name (first, middle, last)			Date of birth	Name (first, middle, last)			Date of birth
Address (street)				Address (street)			
Address (city, state, zip)				Address (city, state, zip)			
Sex ☐ M ☐ F	Height	Weight	Telephone number	Sex ☐ M ☐ F	Height	Weight	Telephone number
Occupation				Occupation			

First Applicant Yes	First Applicant No	Second Applicant Yes	Second Applicant No	Question
❑*	❑	❑*	❑	1. During the past 3 years, have you for any reason consulted or visited a physician or other health care provider, or been hospitalized?
❑*	❑	❑*	❑	2. Have you ever been treated by a member of the medical profession for any of the following: heart, lung, kidney, liver, nervous system, or mental health disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse or addiction?
❑*	❑	❑*	❑	3. Have you ever been diagnosed by a member of the medical profession as having AIDS (Acquired Immunodeficiency Syndrome), or any disorder of your immune system; or had a test showing evidence of antibodies to the AIDS virus, HIV (Human Immunodeficiency Virus)?

**If any answer is YES, indicate on separate sheet of paper the person treated, reason for consultation, dates, names/address of physicians, diagnosis and treatment.*

Answers provided on this application are representations of each person signing below. False or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied. To determine my insurability, I authorize any health care provider, insurance company, or Medical Information Bureau (MIB) to give medical or non-medical information about me including alcohol and drug abuse to the Minnesota Life Insurance Company and its reinsurers. I authorize Minnesota Life, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize all said sources except MIB to give such information to any agency employed by Minnesota Life Insurance Company to collect and transmit such information. I must notify Minnesota Life of any changes in my health which occur between the date of this application and the date it is approved. This authorization is valid for 24 months. These answers are true and complete to the best of my knowledge and belief. By signing the application, I acknowledge the receipt of the Consumer Protection Disclosures, Privacy Notice and other disclosures provided with this application. I authorize my lender to bill and collect premium payments as specified. I understand that coverage does not begin until approved and the first premium is received by Minnesota Life Insurance Company. I understand that fees may be paid by the insurer in connection with this coverage to the sponsor of this plan and/or its affiliates or designates.

Any person who, with intent to defraud or knowing that he/she 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.

First applicant signature	Date (mm/dd/yy)	Second applicant signature	Date (mm/dd/yy)
X		X	

For Office Use Only

Beneficiary			Case number	Loan balance
Maximum term	Premium	Approval date	Loan number	Initial amount of insurance

POS Escrow

Consumer Privacy Notice

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or rights, you may contact:

Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, Massachusetts 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

Consumer Protection Disclosures

Insurance products are not deposits or other obligations of, or guaranteed by, the financial institution or any of its affiliates. Insurance products are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, the financial institution, or any of its affiliates. The financial institution may not condition an extension of credit on either: (1) your purchase of an insurance product from the financial institution or any of its affiliates; or (2) your agreement not to obtain, or a prohibition on you from obtaining, an insurance product from an unaffiliated entity. By signing this application, you acknowledge your receipt of these disclosures.

Rejection Statement

I/We hereby acknowledge that I/we have been given an opportunity to apply for Mortgage Life Insurance which is available to mortgage loan customers of the named financial institution in connection with my/our loan number.
At this time I/we *do not* wish to apply for Mortgage Life Insurance to pay off or reduce the loan balance in the event of the death of the insured borrower(s).

I/We understand that even though I/we may have signed This "Rejection Statement," I/we may still apply for this protection in the future.

First borrower's signature	Date	Co-borrower's signature	Date
X		X	