

THE CINCINNATI LIFE INSURANCE COMPANY

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

513-870-2000

Application for Life Insurance

Please print or type all information

1. Proposed Insured (first, middle, last)				2. <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Birth Date	
4. Street Address		Apt. #	City		State	Zip	5. Birthplace (State)
6. Social Security No.		7. Driver's Lic. No. and State			8. Occupation		
9. Daytime Phone # _____		Evening Phone # _____		Cell Phone # _____			
10. Has the Proposed Insured used any tobacco or nicotine products in the last 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No							
11. Plan		12. Face Amount			13. UL Death Benefit Option <input type="checkbox"/> A <input type="checkbox"/> B		
14. Optional Benefit Riders: Other Riders							
<input type="checkbox"/> Accidental Death		\$ _____	Amount	<input type="checkbox"/> Waiver of Premium/COI		<input type="checkbox"/> _____	
<input type="checkbox"/> Insured Insurability (GPO)		\$ _____	Amount	<input type="checkbox"/> Extension of Maturity Date		<input type="checkbox"/> _____	
<input type="checkbox"/> Children's Term		# _____	Units	<input type="checkbox"/> Accelerated Benefit		<input type="checkbox"/> _____	
15. Premium Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> List Bill <input type="checkbox"/> Bank-O-Matic (complete authorization)							
16. Amount Remitted with Application \$ _____				17. Automatic Premium Loan (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No			
18. Owner, if other than the Proposed Insured (first, middle last)				19. Relationship		20. Date of Birth	
21. Street Address		Apt. #	City		State	Zip	22. Social Security No. or EIN
23. Primary Beneficiary (first, middle, last)					24. Relationship		
25. Contingent Beneficiary (first, middle, last)					26. Relationship		
27. Does the Proposed Insured have any life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company? (Complete any applicable replacement forms) <input type="checkbox"/> Yes <input type="checkbox"/> No							
If "Yes," list and indicate if it is to be replaced, changed or borrowed against as a result of this application.							
Insurer		Policy Number		Amount		Replaced?	Yes No
_____		_____		_____		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
_____		_____		_____		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

I acknowledge receipt of the Conditional Premium Receipt (if one is given) and of 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: _____ City _____ State On: _____ 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'S STATEMENT: I certify that I have truly and accurately recorded on this Application the information supplied by the Proposed Insured and/or applicant. I further certify that the Proposed Insured does does not have existing life insurance or annuities in force with The Cincinnati Life Insurance Company or any other company and that the policy applied for will will not replace or change any other life insurance or annuity presently in force. I certify that I have provided the Applicant with a copy of The Cincinnati Life Insurance Company's Notice of Privacy Practices.

Signature of Agent

Agent's Name (please print)

Agent's Code Number

Agency Name (please print)

THE CINCINNATI LIFE INSURANCE COMPANY

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

HIV TEST INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health or disability insurance for which you may apply in the future.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE-TESTING CONSIDERATION: Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS: All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not, by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive test results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to MIB. MIB is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. There will be no record with MIB that you had a positive HIV antibody test; however, there will be a record that you have some blood, oral fluid or urine abnormality. If you apply to another MIB Member company for insurance coverage, MIB, upon request, will supply the information on you in its file to that Member.

TEST RESULTS: While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION: For more information about AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

CONSENT FOR HIV TESTING: I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within 90 (ninety) day period.

In the event of a positive test result:

_____ Send the result to me at:

(Address)

_____ I authorize The Cincinnati Life Insurance Company to send the result to another person:

(Name)

(Address)

_____ I authorize The Cincinnati Life Insurance Company to send the result to the following physician or health care provider:

(Physician's Name)

(Address)

AUTHORIZATION

(Name of applicant)

(Signature of applicant)

(date)

(Signature of legal guardian, if any)

(date)

(Signature of person obtaining consent)

(date)

**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)

KEEP THIS



THE CINCINNATI INSURANCE COMPANIES

THE CINCINNATI INSURANCE COMPANY
THE CINCINNATI CASUALTY COMPANY
THE CINCINNATI SPECIALTY UNDERWRITERS INSURANCE COMPANY
THE CINCINNATI INDEMNITY COMPANY
THE CINCINNATI LIFE 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*

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CINCINNATI LIFE INSURANCE COMPANY**
P.O. BOX 145496, CINCINNATI, OHIO 45250-5496

**THE APPLICATION PROCESS
TO BE LEFT WITH PROPOSED INSURED**

Thank you for choosing The Cincinnati Life Insurance Company. Now that the application is complete, we would like you to know what happens next.

There are essentially four steps to applying for life insurance through the Lite Horizons process:

Phone Call

An interviewer will contact you in the next few days to obtain more information about your health and medical history and to schedule your medical exam, if one is necessary.

Medical Exam (if required)

Typically, the exam will take place within a week of the phone interview in either your home or place of business. This is done at no cost to you but, at the time the policy is delivered, you can arrange to have the results sent to you. If you are unable to keep your scheduled appointment, please notify your agent.

Process

Upon the completion of your interview and receiving your exam, The Cincinnati Life Insurance Company will review your application for approval.

Policy

Once your application has been approved, the policy will be mailed to your agent for your final review.

That's it! Applying for life insurance could not be any easier. If you have any questions about your application or this process, please contact your agent.

KEEP THIS

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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 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 and personal characteristics. I understand that: 1. I may request to be interviewed if an investigative consumer report is obtained; 2. I am entitled to receive a copy of the report; and 3. 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.