



Application Supplement for Adding Benefits and Policy Changes

P. O. Box 35768 Tulsa, OK 74153

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|----------|--|-----------|-------|-----|------|
| 1 | Applicant (Print Name --- First, Middle Initial, Last) | Birthdate | Month | Day | Year |
|----------|--|-----------|-------|-----|------|

I, _____ hereby amend the application which is part of Policy Number _____, and agree that the following shall be admendment to and form a part of that application and that policy. This supplement is to be used to consider the insurance requested herein for the family members listed below:

| | | |
|---|--|---|
| <input type="checkbox"/> Policy Change | <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Accidental Death Benefit - Amount \$ _____ |
| <input type="checkbox"/> Reconsideration of Premium Class | <input type="checkbox"/> Policy Conversion | <input type="checkbox"/> Spouse Insurance Rider - Amount \$ _____ |
| | Policy Type: _____ | <input type="checkbox"/> Children Insurance Rider - Amount \$ _____ |

| Person(s) to be insured (Print First, Middle, Last Name) | Relationship | Birthdate | Age | Height | Weight |
|--|--------------|-----------|-----|--------|--------|
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Medical & Related Information: Complete questions for each person listed above.

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|-----------|---|--------------------------|---|
| | Yes | No | |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | Will life insurance or annuity of any company be replaced or changed if insurance applied for is issued? |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | Does any family member plan to travel or live outside of the United States? |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | Has any family member, within 2 years, flown as a pilot or engaged in motor vehicle racing, hang gliding, sky diving or scuba diving? If yes, please submit aviation or avocations supplement. |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> | Has any family member, within the last 2 years, had motor vehicle moving violations or their license suspended? |
| 6 | <input type="checkbox"/> | <input type="checkbox"/> | Has any family member used tobacco products within the last 12 months? |
| 7 | <input type="checkbox"/> | <input type="checkbox"/> | Has any family member had insurance refused, or offered only with an extra premium? |
| 8 | <input type="checkbox"/> | <input type="checkbox"/> | Has any family member consulted a physician within the last 3 years? If yes, please give date, reason, name, address and phone. |
| 9 | Has any family member ever had or been treated for any of the following conditions? | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | a. Chest Pain, Heart disease, stroke, high blood pressure or lung disease? |
| | <input type="checkbox"/> | <input type="checkbox"/> | b. Diabetes, mental illness, convulsions, paralysis, or any disease of the brain or nervous system? |
| | <input type="checkbox"/> | <input type="checkbox"/> | c. Alcohol or drug use, or any disease of the stomach, intestines, liver or kidneys? |
| | <input type="checkbox"/> | <input type="checkbox"/> | d. Cancer, tumor, disease of the lymph glands, immune system or blood? |
| | <input type="checkbox"/> | <input type="checkbox"/> | e. Acquired Immune Deficiency Syndrome ("AIDS") or AIDS related conditions; or susceptible to AIDS in view of having tested positive for antibodies to the AIDS virus. |
| 10 | <input type="checkbox"/> | <input type="checkbox"/> | Was any child listed above under 3 years old, premature at birth, or weighed less than 5 pounds at birth? |

Additional Information (Please list question number and full detail of YES answers including the name of the family member)

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The answers above are true and complete to the best of my knowledge and belief. **I agree that coverage will not take effect until this supplement is approved by Leaders Life and paid for. However, any Temporary Insurance Agreement in force under the application when this Supplement is paid for will apply to this Supplement, subject to the following rule for any spouse or children riders. For those riders, the Agreements will apply only to spouse and children who are insurable under Leaders Life rules at standard rates when this Supplement is paid for.**

THIS AGREEMENT (or photograph copy) authorizes any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Informaiton Bureau or other organization, institution or person, that has any records or knowlege of me or my health, to give to Leaders Life Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law.

| | | | |
|-----------|--------------------------|--------------------------|--|
| | Yes | No | |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | Do you know, or have reason to believe, that any existing insurance or annuity will be replaced if insurance requested in this supplement is issued? |

Signature of Applicant: _____ Date: _____ Signature of Agent: _____
(or spouse if to be insured)

Signature of Spouse Owner: _____ Date: _____ Signed at (City & State): _____