Physicians Life Insurance Company®

Omaha, Nebraska

ANNUITY APPLICATION

Annuity plan applied for: Annuity Date (Date on which benefit payments are to begin.) / /

Initial Premium Amount $

Type of Plan ☐ Non-Qualified ☐ 1035 Exchange ☐ SEP-IRA Rollover ☐ IRA Transfer ☐ 403(b) Rollover
☐ IRA Rollover from Qualified Plan ☐ IRA ☐ 403(b) ☐ SEP-IRA ☐ OTHER

Annuitant Information	**Joint Annuitant**
Full Name	Full Name
Address	Address
City State Zip	City State Zip
Social Security Number	Social Security Number
☐ Male ☐ Female Date of Birth / /	☐ Male ☐ Female Date of Birth / /

Owner Information (If different from Annuitant.)	**Joint Owner**
Full Name	Full Name
Address	Address
City State Zip	City State Zip
Social Security Number	Social Security Number
☐ Male ☐ Female Date of Birth / /	☐ Male ☐ Female Date of Birth / /

Beneficiary(ies) (Show % each is to receive) Relationship Social Security Number

Primary

Contingent

Comments

Confinement Status Is the proposed Owner(s) currently a patient in a hospital, nursing home or extended care facility? ☐ Yes ☐ No

Terminal Illness Status Has the proposed Owner(s) been diagnosed with a terminal illness? ☐ Yes ☐ No

Home Health Care Status Is the proposed Owner(s) capable of performing at least 4 of the 5 activities of daily living (eating, dressing, bathing, transferring and toileting) and currently not receiving home health care services? ☐ Yes ☐ No

Is the contract applied for to replace or change any existing Life Insurance or Annuity contract? ☐ Yes ☐ No

To the best of my knowledge and belief, the statements and answers contained in this application are true and complete and the above Social Security and/or Taxpayer Identification numbers are correct. I hereby apply for the annuity specified above. I understand that the annuity contract will not go into effect until the premium is paid and the contract is issued.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Please make check payable to: **Physicians Life Insurance Company.**

City _____ State _____ this _____ day of _____ , _____

Annuitant's Signature

Joint Annuitant's Signature

Owner's Signature (If other than Annuitant)

Joint Owner's Signature

AA112BB

Agent's Report To the best of your knowledge, does the policy applied for involve replacement or modification of any existing Life Insurance or Annuity contract? ☐ Yes ☐ No

If yes, indicate which cost basis and submit required replacement forms. ☐ Life Insurance ☐ Annuity Cost Basis $ _____

I certify that only company approved sales material was used in connection with this sale, and copies of all sales materials used were left with the applicant.

Signature of Agent Telephone ( ) Agent Number

Agent Name Agent License ID# Date Signed

Agent Name (Print) Agent Number Percentage

Agent Name (Print) Agent Number Percentage

Please submit Application and Payment to:

1205 **Physicians Life Insurance Company, P.O. Box 2316, Omaha, NE 68172-4081**