

STERLING INVESTORS LIFE INSURANCE COMPANY

Home Office: Rome, Georgia
 Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846

CONVALESCENT CARE INSURANCE POLICY APPLICATION

APPLICANT

| | | | | |
|------|---------------|-------|------|--|
| Last | | First | | MI |
| AGE | DATE OF BIRTH | | SEX | |
| | Month | Day | Year | <input type="checkbox"/> Male <input type="checkbox"/> Female |

RESIDENCE ADDRESS

Street: _____
 City: _____
 State: _____ Zip Code: _____
 Area Code: _____ Telephone Number: _____

SOCIAL SECURITY NUMBER

Underwriting Risk Classification Question

Have you used any form of tobacco in the past five years? Yes No

BENEFIT OPTIONS

Convalescent Care Insurance Policy Maximum Daily Benefit Amount \$ _____ Maximum Benefit Period 180 Days 360 Days

Optional Riders

In Home Convalescent Care Rider Compound Inflation Protection Rider

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? Yes No
2. Do you require assistance with shopping, housekeeping or cooking? Yes No
3. During the past two (2) years have you:
 - (a) been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? Yes No
 - (b) required any assistance with mobility including the use of a walker, single cane, quad cane, walking aids, wheelchair, or scooter? Yes No
4. Are you bedridden? Yes No
5. Are you currently hospitalized or have you been hospitalized two or more times within the past year? Yes No
6. Within the past two years, have you been advised to have kidney dialysis? Yes No
7. Within the past two years, have you had a heart attack, stroke or heart valve surgery? Yes No
8. Within the past two years, have you had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse? Yes No
9. Within the past two years, have you been recommended to have surgery for cataracts, joint replacement, a heart condition or other in-patient surgery but not had such surgery? Yes No
10. Have you had or been told by your physician you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
11. Have you had or been told by your physician you needed amputation due to disease? Yes No
12. Are you an insulin dependent diabetic? Yes No

Effective Date: _____

Special Requests: _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Bank Draft Annual Semiannual Quarterly Monthly Bank Draft

PREMIUM CALCULATION

| | |
|--|-----------|
| CONVALESCENT CARE ONLY PREMIUM | \$ |
| IN HOME CONVALESCENT CARE RIDER PREMIUM | \$ |
| COMPOUND INFLATION PROTECTION RIDER PREMIUM | \$ |
| SUBTOTAL | \$ |
| LESS SPOUSAL DISCOUNT (IF APPLICABLE) | \$ |
| TOTAL PREMIUM PAID WITH APPLICATION | \$ |

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? Yes No
2. Did you have another limited benefit policy in force during the last six (6) months? Yes No

If yes, with which company: (Name and address): _____

Policy Number: _____ If that policy lapsed, when did it lapse? _____
 Daily Benefit Amount: \$ _____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? Yes No

If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information requested is necessary for evaluation and underwriting of my application for the insurance policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the insurance policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime.

I acknowledge receiving an outline of coverage for the policy applied for.

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature: _____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature

Date

Agent's Printed Name

Agent Number