

OWNER INFORMATION

First Name TANOAH Morgan M.I. V Last Name Morgan
 Email tanoah.morgan @ verizon.net
 Address 16300 Marsham Dr Apt # _____ City Upper Marlboro State MD Zip 20772
 Phone 301-793-6389

APPLICANT INFORMATION - All applicants must permanently reside in the United States.

First Name Emelda Sterling M.I. J Last Name Sterling Relationship to Owner mother
 Address 3510 Edward St Apt # _____ City Springdale State MD Zip 20774
 Phone 301-780-6382 Social Security # 435-60-4840 Age 81 Date of Birth 01-09-1937 Sex Male Female

BENEFICIARY INFORMATION

Primary First Name TANOAH M.I. V Last Name Morgan Relationship daughter
 Address 16300 Marsham Dr Phone 301-793-6389
 Contingent First Name Bucas M.I. _____ Last Name Sterling III Relationship son

Coverage Amount	\$ 2000.00
Monthly Premium	\$ 32.46
Rider Premium	\$ _____
TOTAL MONTHLY PREMIUM	\$ 32.46

RIDER OPTIONS Child Rider Yes No # of Unit(s) Per Child _____ AD&D Rider Yes No # of Unit(s) _____

PLAN Final Expense 20 Year Pay Modified Death Benefit
PAYMENT METHOD Monthly Draft Annual Quarterly Semi-Annual Monthly Direct
DUE DATE 9 (1st thru 28th only)

TOBACCO QUESTION In the past twelve (12) months, has the applicant used any form of tobacco? Yes No

UNINSURABLE CONDITIONS

- Has the applicant tested positive for HIV or been diagnosed by a physician as having AIDS or a life expectancy of twelve (12) months or less? Yes No
- Is the applicant currently bedridden, hospitalized, in a care facility, or receiving hospice care? Yes No

SIGNIFICANT HEALTH CONDITIONS - If the answer to any health question is "Yes", your death benefit will be modified.

- In the past two (2) years, has the applicant been diagnosed with, been treated by a physician, or taken medication for any of the following conditions:
- Disease of the heart, including heart attack, heart surgery, or congestive heart failure? Yes No
 - Disease of the circulatory system, including stroke, aneurysm, or been advised to have surgery to improve circulation? Yes No
 - Cancer, other than basal cell skin cancer? Yes No
 - Disease of the lungs, including COPD or emphysema, other than asthma? Yes No
 - Disease of the liver or kidney, or had an organ transplant? Yes No
 - Alzheimer's disease, dementia, organic brain syndrome, or ALS (Lou Gehrig's disease)? Yes No
 - Alcohol or drug abuse? Yes No
 - Complications of diabetes, including amputation, diabetic coma, blindness, or kidney disorder? Yes No
 - Has the applicant had or been advised to have a diagnostic test relating to any of the questions listed above, except for those relating to the Human Immunodeficiency Virus (AIDS virus), for which results have not yet been received? Yes No

REPLACEMENT 1. Does the applicant have existing life insurance or annuity contracts? Yes No
 2. Will this policy replace or change other insurance or annuities? Yes No
 If question two (2) is answered "yes", list: Company _____ Policy # _____

AUTOMATIC PREMIUM LOAN Is Automatic Premium Loan requested? Yes No **DELIVERY** Mail Policy to: Owner Producer

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two (2) years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance. I understand that coverage takes effect when this application has been approved by the Company and the first premium is paid.

Signature of Owner [Signature] Signature of Applicant [Signature] Signed in State MD Date 12-09-2018

PRODUCER'S CONFIRMATION Are there existing life insurance and/or annuity contracts on the life of the applicant? Yes No To the best of my knowledge, replacement is is not involved in this transaction. If replacement is involved, I presented and read the applicant a notice regarding replacement.

Signature of Producer [Signature] Producer's Number 27-0125570
 First Name TANOAH Last Name Morgan

FUNERAL CONSUMER GUARDIAN SOCIETY (FCGS) ENROLLMENT - Free Benefit Please enroll me as a non-voting FCGS member. Yes No

**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policies or contracts? YES NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? YES NO


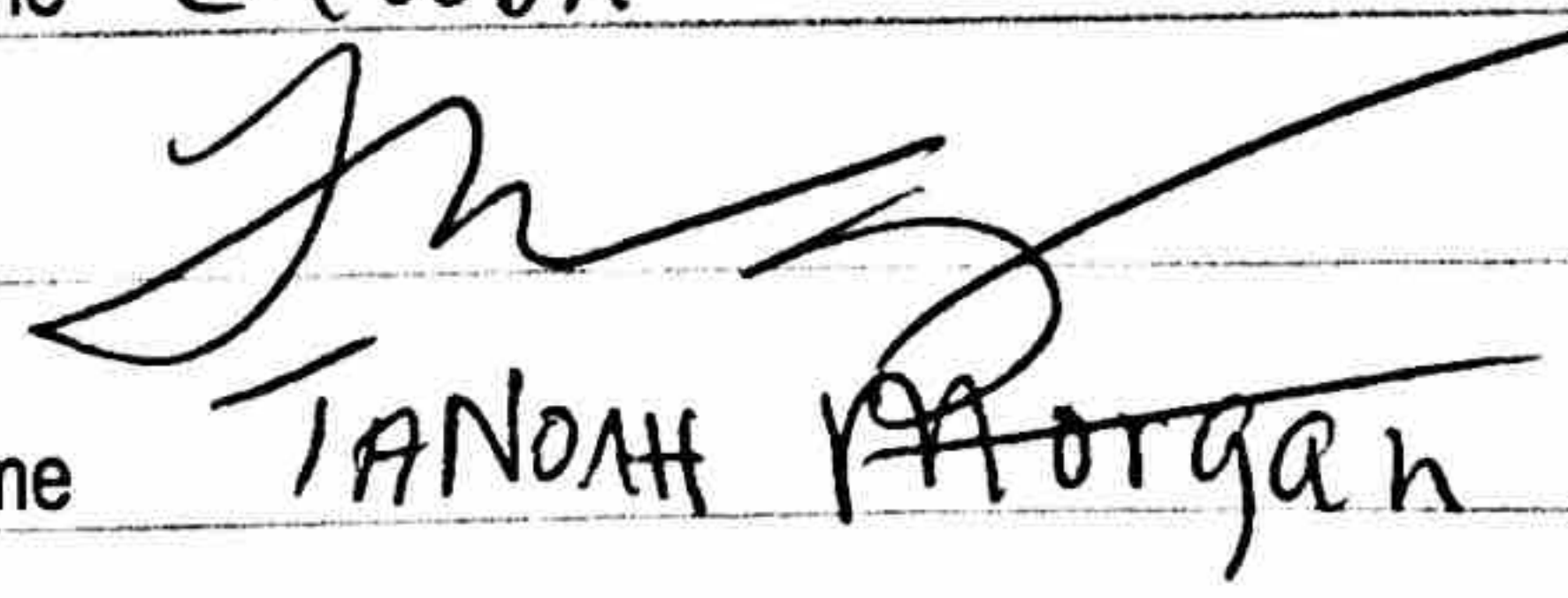
If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) Financing (F)
1.				
2.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature		Date	12 - 09 - 2018
Applicant's Printed First Name	EMERALD	Applicant's Printed Last Name	STERLING
Producer's Signature		Date	12 - 09 - 2018
Producer's Printed First Name	IAN MORGAN	Producer's Printed Last Name	Morgan

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Authority to honor payments drawn by and payable to
LINCOLN HERITAGE LIFE INSURANCE COMPANY
 4343 E. Camelback Rd. Suite 400 Phoenix, AZ 85018

Checking or Savings Account		Payment Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings	
Authorized Payor		2nd Authorized Payor	
First Name	<i>Emelda</i>	First Name	
Last Name	<i>Sterling</i>	Last Name	
Routing Number	<i>255071833</i>	Telephone Number	<i>301 - -</i>
Account Number	<i>1160000111763</i>	City	<i>BOWIE</i>
	Financial Institution		State
	<i>NASA FCU</i>		<i>MD</i>

Credit Card		Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover	
		Payment Type: <input type="checkbox"/> Debit <input type="checkbox"/> Credit	
Name as it Appears on the Card			
First Name		Sequence Number	
Last Name		Expiration Date	
Billing Address		City	State Zip

Please withdraw my initial premium on *- - 20* OR
 Immediately upon receipt at home office
 Please draft my recurring monthly payment on the due date indicated on the application OR
 Please draft my recurring monthly payment on the 1st 2nd 3rd 4th *9th* of the month.
 (Monday - Friday only)

I authorize Lincoln Heritage Life Insurance Company (hereafter "you") to collect the initial premium and any future payments for this insurance by electronic or other means from the account identified above. I agree that the treatment of such payment, and all rights with respect to it, will be the same as if it were signed and initiated by me. I further agree that if any check, draft or debit is dishonored for any reason, you will not be under any liability, even though dishonor results in the forfeiture or lapse of insurance. This authorization is to remain in effect until you receive written notice from me of its revocation, unless you end it earlier. I understand that no insurance will go into effect until Lincoln Heritage has (a) received and approved the application for life insurance, (b) issued a policy based on the application, (c) withdrawn the first premium from the designated account. The applicant(s) must be alive at the time the payment is honored.

Authorized Signature



Date *12 - 09 - 20 18*

Please include a void check from the account to be drafted if initial payment will be a checking account draft.

Indemnification Agreement - TO: The Financial Institution named above.

"In consideration of your compliance with the authorization of the depositor named above, we agree to indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from execution of any check, draft or order, whether or not genuine, purporting to be drawn by the Lincoln Heritage Life Insurance Company to its own order and received by you in the regular course of business, and to defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing request, or in any manner arising by reason of your participation in the foregoing plan of premium collection." Authorized by a resolution adopted by the Board of Directors of the Lincoln Heritage Life Insurance Company.