



Trinity Life Insurance Company

HOME OFFICE

7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133

Phone: (918) 249-2438 • Fax: (918) 249-2478

ADMINISTRATIVE OFFICE

PO BOX 5205 • FRANKFORT, KY 40602-5205

Phone: (866) 440-1357 • Fax: (502) 875-7084

PROPOSED INSURED CONSENT FORM

PROPOSED INSURED: _____

OWNER: _____

CO-OWNER: _____

This is to certify that the undersigned Proposed Insured gives full permission to the application for life insurance on his/her life.

AUTHORIZATION

With this form (or a photographic copy of it), I authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically-related facility, insurance company, reinsurer, the Medical Information Bureau, or other person, organization or institution, that has any records for knowledge of me for whom the application is made or my health, to give to Trinity Life Insurance Company, or it's reinsurers, any such information and to testify as to such information, all to the extent permitted by law. This authorization shall be valid for 24 months from the date signed. I understand that I may revoke this authorization by so stating in writing sent to Trinity Life Insurance Company's Underwriting Department at the Administrative Office.

I also acknowledge receipt of the notices required by the Fair Credit Reporting Act and the Medical Information Bureau. A photographic copy of this authorization shall be as valid as the original.

I acknowledge that I have been given a copy of the application and to verify that all information on the application is complete and true as of the date of this Consent to the best of my knowledge, except for:

EXCEPTIONS: (If none, state "NONE") (If more space is needed to completely and accurately supply the information requested, attach additional paper.)

_____ Date

_____ Signature of Proposed Insured

_____ Witness