

# INDIVIDUAL ANNUITY APPLICATION

**EquiTrust Life Insurance Company®**

7100 Westown Parkway, Suite 200

West Des Moines, Iowa 50266-2521

(866) 598-3692 [www.EquiTrust.com](http://www.EquiTrust.com)

Mailing Address: PO Box 14500

Des Moines, Iowa 50306-3500

**Product** \_\_\_\_\_

Product disclosure must be submitted with Application.

**Contract #** \_\_\_\_\_

(Home Office Use Only)

Agent Name	Agent Phone #	Agent #	Split %

All references to "the Company" shall mean EquiTrust Life Insurance Company, West Des Moines, Iowa.

## SECTION A – OWNER INFORMATION

Type of Ownership:  Individual  Joint Ownership  Trust  Entity (If Trust or Entity complete additional required forms.)

Owner			Joint Owner (Not available for Qualified Plans)		
Full Name (first-middle-last)		Gender	Full Name (first-middle-last)		Gender
Social Security Number	Age	Birth Date	Social Security Number	Age	Birth Date
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single		
Permanent Physical Address (Required - No PO Box)			Permanent Physical Address (Required - No PO Box)		
City	State	Zip Code	City	State	Zip Code
Mailing Address (if different)			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
Home Phone Number	Daytime Phone Number		Home Phone Number	Daytime Phone Number	
E-mail Address			E-mail Address		

## SECTION B – ANNUITANT INFORMATION

Annuitant (If left blank, will be same as the Owner)			Joint Annuitant (Not available for Qualified Plans)		
Full Name (first-middle-last)		Gender	Full Name (first-middle-last)		Gender
Social Security Number	Age	Birth Date	Social Security Number	Age	Birth Date
Permanent Physical Address (Required - No PO Box)			Permanent Physical Address (Required - No PO Box)		
City	State	Zip Code	City	State	Zip Code
Mailing Address (if different)			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
Home Phone Number	Daytime Phone Number		Home Phone Number	Daytime Phone Number	
E-mail Address			E-mail Address		

**SECTION C – TAX QUALIFICATION**

Non-Qualified   
  IRA Transfer   
  IRA Rollover   
  IRA Contribution – Tax Year \_\_\_\_\_   
  Roth IRA  
 Roth Conversion   
  Inherited/Stretch IRA(form ET-INHIRA required)   
  SEP IRA   
  SIMPLE IRA   
  Other\_\_\_\_\_

**SECTION D – PREMIUM PAYMENT**

Check included	\$
Check in transit	\$
Anticipated total amount from external transfer(s) to be requested by EquiTrust	\$
Anticipated total amount from external transfer(s) to be requested by Agent or Owner	\$
<b>Total Premium</b>	\$

**SECTION E – EXISTING COVERAGE/REPLACEMENT**

Do you have any existing life insurance policies or annuity contracts with EquiTrust or any other company? If “Yes” and required by your state, complete replacement form(s)  Yes  No  
 Will this annuity partially or completely replace any existing life insurance policies or annuity contracts? If “Yes” complete replacement forms(s).  Yes  No

**SECTION F – BENEFICIARY DESIGNATION – Death Proceeds to be paid to named beneficiaries upon death of Contract Owner. Spousal continuation available only if surviving spouse is named as the sole primary beneficiary. Beneficiary proceeds will be split equally if no percentages are provided.**

The Owner agrees that, in the event of his or her death before the annuity contract is issued and/or delivered, the beneficiary designation below shall be treated as a transfer-on-death designation for the premium intended for this annuity contract.

<b>Primary Beneficiary</b>				
Full Name (first-middle-last)		Birth Date/Trust Date	SSN/TIN	Share %
Address		City	State	Zip
Phone Number	Relationship	E-mail Address		
<input type="checkbox"/> <b>Primary Beneficiary</b> <input type="checkbox"/> <b>Contingent Beneficiary</b>				
Full Name (first-middle-last)		Birth Date/Trust Date	SSN/TIN	Share %
Address		City	State	Zip
Phone Number	Relationship	E-mail Address		
<input type="checkbox"/> <b>Primary Beneficiary</b> <input type="checkbox"/> <b>Contingent Beneficiary</b>				
Full Name (first-middle-last)		Birth Date/Trust Date	SSN/TIN	Share %
Address		City	State	Zip
Phone Number	Relationship	E-mail Address		
<input type="checkbox"/> <b>Primary Beneficiary</b> <input type="checkbox"/> <b>Contingent Beneficiary</b>				
Full Name (first-middle-last)		Birth Date/Trust Date	SSN/TIN	Share %
Address		City	State	Zip
Phone Number	Relationship	E-mail Address		

Please check here if you are attaching additional beneficiary information.

**SECTION G – SPECIAL REQUESTS, REMARKS, CORRECTIONS OR ENDORSEMENTS**


## SECTION H – NOTICE

State insurance law may prohibit the Owner of an annuity Contract from entering into any agreement to sell, transfer, or assign an annuity Contract prior to the date the Contract was issued, or within a period of time specified by state law after the Contract is issued. Consult your legal advisors if you have questions about these matters.

## SECTION I – SIGNATURES

Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), (2) I am not subject to backup withholding due to failure to report interest and dividend income, (3) I am a U.S. person (including a U.S. resident alien) and (4) I am exempt from FATCA reporting. **Cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding.**

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

I/We declare that all statements in this Application are true to the best of my/our knowledge and belief, and agree that this Application shall be a part of the Contract issued by the Company. Acceptance of any Contract issued on this Application shall constitute ratification of any corrections, additions or changes made by the Company and recorded in the space "Special Requests, Remarks, Corrections or Endorsements" except that no change shall be made as to amount, classification, plan or benefits, unless agreed to in writing. It is understood that no agent or other unauthorized person except an Executive Officer or an Assistant Secretary of the Company is authorized to waive forfeitures, to make or alter Contracts, or to waive any of the Company's rights or requirements.

**If the Contract applied for contains a Market Value Adjustment provision, payments and values are subject to a Market Value Adjustment which may result in upward or downward adjustments in amounts withdrawn or surrendered.**

**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.**

Signed at: City and State

Owner Signature

Date

Joint Owner Signature

Date

## SECTION J – AGENT CERTIFICATION

Will this plan replace any existing life insurance or annuity?  Yes  No

If "Yes", please explain the reason for replacement \_\_\_\_\_

For any replacement, indicate the source of funds to be replaced:

Term Life  Whole Life  Variable Life  Fixed Annuity  Variable Annuity  Other \_\_\_\_\_

- I certify that I used only insurer-approved sales materials with this Application and that an original or a copy of all sales material was left with the Owner.
- I certify that a printed copy of any electronically presented sales material was/will be presented to the Owner no later than the date the Contract is delivered.
- I certify that this application is in accordance with the Company's written statement of the Company's position with respect to the acceptability of replacements.

Agent/Producer Signature

Date