



1. PROPOSED INSURED

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	E-Mail		Age
Home Address <i>Street Address City State ZIP+4</i>				
Personal Phone No. ()	Birth State/ Country		Height ft. in.	Weight lbs.
Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list type(s): Last date of use / / <i>(MM/DD/YYYY)</i>				
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident (<i>green card</i>) status? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, and you have permanent resident status, please list your permanent resident (<i>green card</i>) number:				
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number:				

2. POLICYOWNER (Policyowner is the Proposed Insured unless otherwise indicated)

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No.	Relationship to Insured		Birth State/Country	
Home Address <i>Street Address City State ZIP+4</i>			E-Mail	

3. BENEFICIARIES

Primary Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	

4. PREMIUM PAYMENT MODE

Premium Payment Mode: Annual Semi-Annual Quarterly Monthly (*Automatic*) List Bill

Payor Name <i>First Middle Last</i>	Relationship to Insured
Billing Address <i>Street Address City State ZIP+4</i>	Personal Phone No. ()

5. GENERAL SECTION

1. In the past **2 years**, has the Proposed Insured been charged with or convicted of a felony? (*If YES, coverage cannot be issued.*)..... Yes No

2. Is the Proposed Insured currently negotiating for other insurance coverage? Yes No

3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No

4. Does the Proposed Insured have existing life insurance policies or annuity contracts? Yes No
 If YES, please provide details below, and complete and return the appropriate State Replacement Form.

Name of the company _____ Policy No. _____

6. HEALTH SECTION

Section A—If any question is answered YES, coverage cannot be issued.

- 1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less?..... Yes No
- 2. In the past **12 months**, has the Proposed Insured been medically diagnosed with diabetes or been treated for uncontrolled diabetes or any complications thereof, including numbness, amputation, circulation, eye or kidney disorder, coma or insulin shock; needed assistance or personal supervision to perform any activities of daily living (*toileting, transferring, continence, eating, bathing, dressing, grooming, walking, managing medications*); had or been advised to have brain, heart or circulatory surgery; had chronic respiratory disease such as chronic obstructive pulmonary disease (*COPD*) or emphysema; been treated with oxygen; been diagnosed with heart disease or had myocardial infarction (*heart attack*) or heart-related chest pain (*angina*); or been confined to a nursing facility or received inpatient services at a medical facility for more than 48 continuous hours?..... Yes No
- 3. Has the Proposed Insured **ever** been medically diagnosed as having or been treated for (*including office visits, medication or surgery*): leukemia, Hodgkin's disease, a blood or bleeding disorder, connective tissue disorder, Parkinson's disease, systemic lupus erythematosus (*SLE*), amyotrophic lateral sclerosis (*ALS*), cirrhosis, chronic hepatitis B, C or D, liver disease, kidney disease with dialysis treatment, Alzheimer's disease, dementia, lymphoma, lymph node enlargement or malignant melanoma; or received or been advised to receive an organ or tissue transplant; or in the past **5 years** been medically diagnosed with or been treated for internal cancer?..... Yes No
- 4. Has the Proposed Insured been medically diagnosed as having cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease? Yes No
- 5. Has the Proposed Insured had a medical test and not yet received the results, or been advised to have surgery or receive medical treatment? .. Yes No
- 6. In the past **5 years**, has the Proposed Insured **ever** been medically diagnosed as having or been treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*), or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No

Section B—Complete only if all answers in Sections A were NO. Any YES answers in Section B limit consideration to Graded Benefit Whole Life coverage.

- 1. In the past **90 days**, has the Proposed Insured been, or are they now, confined to a psychiatric facility or receiving home health care?..... Yes No
- 2. In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated for: congestive heart failure or cardiomyopathy, stroke, aneurysm or sleep apnea; or had or been advised to have treatment for any drug or alcohol abuse?..... Yes No
- 3. In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of stents or cardiac defibrillator?..... Yes No
- 4. Has the Proposed Insured **ever** been treated for (*including office visits, medication or surgery*): diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack (*TIA*) or heart disease?..... Yes No

If all questions in Sections A and B are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

7. POLICY INFORMATION

Plan of Insurance: Level Benefit Whole Life Graded Benefit Whole Life Initial Death Benefit \$ _____

AGREEMENT

I, (*We*) have read the above questions and answers and declare that they are complete and true to the best of my (*our*) knowledge and belief. I (*We*) agree that this application shall form a part of the policy if attached thereto.

I (*We*) agree that:

- 1. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
- 2. **In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.**
- 3. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

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

Signed at _____ on _____ / _____ / _____
City State Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Owner(s) (If other than Proposed Insured)



FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

- 1. a. What amount was collected with this application? \$ _____
- b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? Yes No
- c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? Yes No

- 2. a. Did you personally see the Proposed Insured on the date of application? Yes No
 - b. How well do you know the Proposed Insured? Well Slightly Not at all
 - c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured?... Yes No
- If YES, please provide details _____

- 3. a. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No
- b. Does the Proposed Insured have existing life insurance policies or annuity contracts?..... Yes No

4. Are commissions to be split? Yes No Agent No. _____ % Agent No. _____ %

AUTOMATIC PAYMENT OPTIONS

- Set up NEW bank withdrawal—signed authorization and voided check attached with the application.
- Add to existing bank withdrawal; indicate other applicant and/or policy numbers _____
- Set up NEW credit card payment—signed authorization attached with the application.

LIST BILL

- Set up NEW list bill—signed authorization attached with the application.
- Add to existing list bill; indicate list bill no. _____ and/or name of company _____

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____ <i>Signature of Soliciting Agent</i>	_____/_____/_____ <i>Date (MM/DD/YYYY)</i>	(____)____/_____ <i>Business Phone No. and Fax No.</i>
_____ <i>Soliciting Agent's Printed Name</i>	_____ <i>Agent No.</i>	_____ <i>Agent's E-mail</i>
_____ <i>Signature of Second Soliciting Agent (if split commission)</i>	_____/_____/_____ <i>Date (MM/DD/YYYY)</i>	_____(____)_____ <i>Agent No. Business Phone No.</i>



LEVEL BENEFIT WHOLE LIFE														
Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE	
	NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob
0	6.95		5.44		27	14.96	16.53	13.65	15.20	54	35.06	42.69	29.88	37.53
1	7.22		5.72		28	15.11	17.04	13.76	15.61	55	36.46	44.56	30.88	38.83
2	7.55		6.03		29	15.30	17.56	13.92	16.04	56	37.91	46.57	31.92	40.17
3	7.90		6.35		30	15.56	18.08	14.13	16.47	57	39.39	48.69	32.99	41.53
4	8.29		6.68		31	15.90	18.59	14.41	16.90	58	40.98	50.99	34.14	42.98
5	8.69		7.03		32	16.30	19.10	14.75	17.34	59	42.77	53.57	35.45	44.59
6	9.11		7.39		33	16.74	19.63	15.12	17.81	60	44.83	56.49	36.98	46.45
7	9.54		7.77		34	17.22	20.20	15.53	18.31	61	47.13	59.71	38.75	48.56
8	10.00		8.15		35	17.73	20.82	15.96	18.86	62	49.61	63.17	40.71	50.89
9	10.47		8.55		36	18.25	21.49	16.40	19.44	63	52.33	66.96	42.84	53.40
10	10.95		8.96		37	18.80	22.19	16.84	20.05	64	55.35	71.16	45.12	56.05
11	11.46		9.25		38	19.38	22.95	17.33	20.71	65	58.72	75.84	47.53	58.82
12	11.98		9.50		39	20.02	23.76	17.87	21.44	66	62.42	80.94	49.97	61.63
13	12.48		9.73		40	20.73	24.66	18.48	22.26	67	66.41	86.40	52.46	64.49
14	12.67		9.96		41	21.53	25.65	19.20	23.20	68	70.73	92.33	55.14	67.53
15	12.85	14.38	10.19	13.24	42	22.41	26.72	20.00	24.26	69	75.42	98.84	58.14	70.87
16	13.03	14.51	10.42	13.37	43	23.33	27.86	20.85	25.37	70	80.51	106.04	61.60	74.63
17	13.21	14.64	10.65	13.51	44	24.29	29.03	21.71	26.50	71	85.65	113.52	65.37	78.50
18	13.40	14.77	10.87	13.64	45	25.25	30.22	22.54	27.60	72	90.83	121.20	69.35	82.40
19	13.58	14.90	11.12	13.77	46	26.20	31.42	23.32	28.66	73	96.55	129.71	73.78	86.80
20	13.76	15.03	11.42	13.90	47	27.16	32.63	24.09	29.71	74	103.36	139.66	78.88	92.17
21	13.94	15.15	12.01	14.01	48	28.14	33.89	24.86	30.76	75	111.76	151.67	84.88	98.99
22	14.12	15.28	12.63	14.10	49	29.16	35.20	25.65	31.83	76	121.70	165.61	91.75	107.27
23	14.30	15.41	13.14	14.20	50	30.25	36.59	26.46	32.93	77	132.84	181.07	99.35	116.68
24	14.48	15.54	13.28	14.34	51	31.38	38.02	27.29	34.05	78	145.25	198.24	107.70	127.23
25	14.66	15.67	13.42	14.55	52	32.54	39.47	28.11	35.17	79	159.04	217.34	116.88	138.90
26	14.82	16.07	13.54	14.85	53	33.76	41.01	28.97	36.32	80	174.28	238.57	126.92	151.69

GRADED BENEFIT WHOLE LIFE									
Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE	
	NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob
40	31.31	39.02	28.13	35.07	61	70.77	97.10	57.94	77.68
41	32.60	40.74	29.37	36.88	62	74.14	102.49	60.30	80.70
42	33.92	42.53	30.61	38.68	63	77.82	108.36	62.87	84.00
43	35.27	44.37	31.84	40.49	64	81.95	114.82	65.69	87.70
44	36.66	46.27	33.06	42.29	65	86.65	121.95	68.84	91.95
45	38.08	48.23	34.27	44.10	66	91.81	129.50	72.17	96.71
46	39.51	50.21	35.46	45.89	67	97.35	137.41	75.64	101.89
47	40.95	52.22	36.61	47.65	68	103.43	146.06	79.47	107.54
48	42.43	54.31	37.77	49.43	69	110.20	155.84	83.86	113.69
49	44.00	56.52	38.96	51.25	70	117.82	167.15	89.04	120.40
50	45.68	58.93	40.20	53.14	71	125.89	179.54	94.73	127.22
51	47.49	61.52	41.48	55.12	72	134.29	192.76	100.79	134.13
52	49.39	64.25	42.77	57.16	73	143.65	207.46	107.62	141.77
53	51.38	67.13	44.11	59.25	74	154.54	-	115.64	-
54	53.46	70.18	45.51	61.37	75	167.58	-	125.25	-
55	55.62	73.41	47.01	63.53	76	182.62	-	136.37	-
56	57.77	76.70	48.56	65.64	77	199.28	-	148.73	-
57	59.93	80.04	50.14	67.70	78	217.74	-	162.44	-
58	62.21	83.61	51.82	69.83					
59	64.73	87.57	53.66	72.16					
60	67.61	92.09	55.71	74.81					

SAMPLE PREMIUM CALCULATION	
Annual Premium per \$1,000	= 58.72
Annual Premium = \$58.72 x 10 (# of \$1000s)	= \$587.20
+ Policy Fee	= \$25.00
Total Annual Premium	= \$612.20
Semi-annual Premium \$612.20 x .51	= \$312.22
Quarterly Premium: \$612.20 x .264	= \$161.62
Monthly Bank Draft: \$612.20 x .088	= \$53.87

YOUR PREMIUM CALCULATION	
Annual Premium per \$1,000	
Annual Premium = (Amount x the # of \$1000s)	
+ Policy Fee	= \$25.00
Total Annual Premium	
Semi-annual Premium	
Quarterly Premium:	
Monthly Bank Draft:	

All rates in U.S. Dollars.

Annual Premiums per \$1,000 of Face Amount.

Policy Fee: \$25.00



Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)





MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company (Assurity) may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include (*but is not limited to*) the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.





NOTICE REGARDING REPLACEMENT

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy, which has been in existence for a period of time, may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of a material misrepresentation or omissions concerning the medical information requested in your application, or) deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options, which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages, which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Applicant's Signature and Printed Name _____
Date (MM/DD/YYYY)

Agent's Signature and Printed Name (if any) _____
*Date (MM/DD/YYYY)**

Agent's Address (Street Address, City, State and Zip)

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED
_____	_____	_____
_____	_____	_____
_____	_____	_____

**To be completed if replacing another policy.
 Signed form to be returned to the home office.
 Applicant to receive a copy of the signed form at the time the application is taken.**





NOTICE REGARDING REPLACEMENT

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy, which has been in existence for a period of time, may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of a material misrepresentation or omissions concerning the medical information requested in your application, or) deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options, which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages, which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Applicant's Signature and Printed Name _____
Date (MM/DD/YYYY)

Agent's Signature and Printed Name (if any) _____
*Date (MM/DD/YYYY)**

Agent's Address (Street Address, City, State and Zip)

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED
_____	_____	_____
_____	_____	_____
_____	_____	_____

**To be completed if replacing another policy.
 Signed form to be returned to the home office.
 Applicant to receive a copy of the signed form at the time the application is taken.**



Retirement Income—

Your policy is designed to pay a guaranteed retirement income of \$ _____ starting at _____ for _____ but not for less than 10 years.
Age, Year Duration

Guaranteed Cash Value—

If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each \$1,000 of insurance. You may borrow against this cash value at an annual _____ percent loan interest charge.

Number of years policy has been in force	5	10	20	Age 45
Total accumulated cash value per \$1,000	_____	_____	_____	_____

Dividends—

The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be. Payment of a dividend is contingent upon the payment of the next premium due.

Number of years policy has been in force	10	20
Illustrated dividend for that individual year per \$1,000 of insurance	_____	_____

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The Proposed Insured has has not requested an earlier delivery of the Index.

Upon request, either the company or agent will furnish you with additional information about the insurance described.

AGENT CERTIFICATION

I hereby certify that I have provided the Proposed Insured with this Disclosure Statement required by Pennsylvania Regulation Section 83.3 (*life applications only*).

_____ _____
Date (MM/DD/YYYY) *Agent's Signature and Printed Name*

The Proposed Insured should retain a copy of this completed form.





ANTI-MONEY LAUNDERING PROGRAM REQUIRES THE AGENT TO COMPLETE THIS FORM, PROVIDING THE FOLLOWING INFORMATION:

Legal name of Policyowner _____ **Social Security Number** _____

Policyowner's occupation _____

1. Source of funds

- | | |
|---|--|
| <input type="checkbox"/> Current income | <input type="checkbox"/> Proceeds of canceled life insurance policy |
| <input type="checkbox"/> Savings | <input type="checkbox"/> From values of existing life insurance policy |
| <input type="checkbox"/> Another person <i>(if so, provide name and relationship below)</i> | <input type="checkbox"/> Other _____ |
| _____ | _____ |

2. Intended purpose of coverage applied for

- | | |
|--|--|
| <input type="checkbox"/> Burial/final expenses | <input type="checkbox"/> Post-death family needs |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Educational expenses |
| <input type="checkbox"/> Mortgage pay-off | <input type="checkbox"/> Business need <i>(e.g. key-person life insurance)</i> |
| <input type="checkbox"/> Funding a charitable contribution | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Periodic income | |

3. Is this application the result of a lead? Yes No

If NO, please provide the information below in questions 4 and 5. If YES, proceed to question number 6.

4. Agent/Policyowner relationship

Length of time known *(in years)* _____ How known? _____

5. Provide any additional information you possess regarding the background of your relationship with the Policyowner

6. The information on this form was obtained from

Name _____

- Policyowner Applicant Payor Other *(specify)* _____

I certify all of the above information is true and correct to the extent of my knowledge and reflects the information provided to me by the individual named above, except where information from me is required.

Producer Signature

Producer No.

Producer Name

Date (MM/DD/YYYY)

Mail or fax (877-864-6630) this completed and signed form along with the application submitted to the home office.



Retirement Income—

Your policy is designed to pay a guaranteed retirement income of \$ _____ starting at _____ for _____ but not for less than 10 years.
Age, Year Duration

Guaranteed Cash Value—

If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each \$1,000 of insurance. You may borrow against this cash value at an annual _____ percent loan interest charge.

Number of years policy has been in force	5	10	20	Age 45
Total accumulated cash value per \$1,000	_____	_____	_____	_____

Dividends—

The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be. Payment of a dividend is contingent upon the payment of the next premium due.

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The Proposed Insured has has not requested an earlier delivery of the Index.

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AGENT CERTIFICATION

I hereby certify that I have provided the Proposed Insured with this Disclosure Statement required by Pennsylvania Regulation Section 83.3 (*life applications only*).

Date (MM/DD/YYYY)

Agent's Signature and Printed Name

The Proposed Insured should retain a copy of this completed form.

