

Bulletin

Presidential Life Anti-Money Laundering Policy

For Life Business (GBL)

- **The writing agent must record the owner and insured's Social Security number and a state issued drivers license** or other state issue identification number, **with issue and expiration dates in the Remarks Section of the GBL application.** This requirement is a good order requirement. **A photocopy of the driver's license or other state issue identification document should be retained in the agent's file.**
- **All Writing and General Agents must be AML training certified** in order to have new business issued. If you have a certificate of AML training completion and you have new business to be issued, please fax to 845-353-6250, attn: AML Officer. If you have LIMRA training, complete the memorandum form and return by fax.

Form available at... http://presidentallife.com/presftp/Memo225_AML-Policy.pdf

If you need to acquire AML training, please take advantage of our third party AML training partner RegEd. A link from our web site to their web site has been established for agents who need the training. The RegEd cost of this training is \$30.00. RegEd will issue an AML training certificate to agents who complete their program. State insurance and CFP CE credit is also available.

If you have AML training other than LIMRA and you cannot provide a certificate at this time, please phone the Agency Department.

If you have any questions or concerns, phone the Agency Department at 800-926-7599 ext. 454, 458, or 455.

Presidential Life Insurance Company Nyack, NY 10960
1-800-926-7599 or 1-888-PRES LIF
www.presidentallife.com





Presidential Life's Graded Benefit Life (GBL)

POLICY ISSUE GUIDELINES

1. The application must be signed in the state in which the insured resides. "Out-of-state" applications are not acceptable. In addition, the application must be completed during a face-to-face meeting between the agent and the insured. This policy is not filed as a "mail order" product.
2. The applicant/insured must be able to sign the application in his or her personal signatory capacity. Applications signed by the holder of a Power-of-Attorney will not be accepted. An applicant may make his or her mark (as opposed to his or her signature), in which case, an explanation of why the individual was unable to sign his or her name (viz. severe palsy) must accompany the application.
3. An individual who is a patient or a resident in any form of health care or nursing home facility is not eligible for coverage.
4. Funeral home and burial societies may not be a party to the application, nor may either of these be named as a policy beneficiary.
5. Premiums are calculated based on **age nearest** birthday and the first full gross modal premium chosen should be submitted at the time of application.
6. Monthly premium payment is available only through (check-o-matic) automatic electronic debit from a checking or savings account.

To establish check-o-matic premium payment requires completion of a Direct Debit Authorization form. Electronic monthly payments drawn on the policy issue date (between the 1st to 28th of each month).

7. If premiums are to be paid monthly, two months' premium must accompany the application when submitted.
8. Pennsylvania Reg Title 31 requires that we receive certification from the agent that Appendix A "Appendix A Disclosure Statement Delivery Receipt" was given to the applicant no later than at the time that the application was signed by the applicant. Please note that Pennsylvania requires a regular Application Part I and a non-medical Part II to be submitted and declined before the GBL application and premium are submitted.
9. **All GBL's must be submitted on a pre-paid basis and we cannot accept post-dated checks.**

COMPENSATION CHARGEBACK POLICY

The death of the insured during the first six months following policy issue results in a 100% chargeback. The death of the insured during the next six months results in a 50% chargeback.

REINSTATEMENT GUIDELINE

Reinstatement following policy lapse requires submission of a reinstatement application for review. The policy will be reinstated if the applicant meets certain requirements. For additional information on reinstatement requirements, contact Presidential Life medical underwriting department.

PRESIDENTIAL LIFE INSURANCE COMPANY

NYACK, NEW YORK 10960

The following information is required with every new application submitted for the GBL product.

GBL Customer Information Transmittal

General agent: (Print name) _____ GA#: _____

Writing agent: (Print name) _____ WA# _____

Insured's Information

Name: (print) _____

Social Security # _____ -- _____ -- _____

Photo Identification (ID) (check one)

- U.S. Driver's License Other _____
 Permanent Resident Green Card Passport
 None. (Explain why.) _____

Issuer _____

Number _____

Date _____ Expiration Date _____

Relationship of All Beneficiaries _____

Owner Information

Name: (print) _____

Social Security # _____ -- _____ -- _____

Photo Identification (ID) (check one)

- U.S. Driver's License Other _____
 Permanent Resident Green Card Passport
 None. (Explain why.) _____

Issuer _____

Number _____

Date _____ Expiration Date _____

MAIL IN THE FOLLOWING ITEMS:

- State of Residence Application** (Properly completed and/or signed). If required, addendum **RPL-NAIC(02)** (See Special State Forms list).
http://presidentiaallife.com/presftp/spec_state_frm.pdf

If the answer to section A is "yes", even if no replacement is taking place, **RPL-NAIC(01) MUST also be completed & signed.**

If a replacement is involved, Section B is to be completed.

- Answer residence application **question #8 correctly.** (Age 40 through 64 = **3 years**, except **WV** = **2 years**, Age 65 or older = **2 years**)

- Modal premium** prior to issue. Monthly mode is **ONLY** available thru Direct Debit. **You must remit two months premium** as well as a Direct Debit form.

- Full mode MUST be submitted for Quarterly, Semi-Annual or Annual modes.**

- DDA Bank Draft form and copy of void check.**

- If **Replacing other insurance. State of Residence Replacement Form.** (See Special State Forms list)

- If **Pennsylvania Application**

- "Appendix A Disclosure Statement Delivery Receipt"** given to the applicant no later than at the time that the application was signed by the applicant.

- Application **1-2000(8/00) PA Part I**, a non-med **Part II**. GBL application **17.7(3/00)(PA)** and **premium** are submitted.

AGENT SECTION:

Already Appointed Agent

- Copy of current license on file with Presidential.
 Memo225_AML-Policy signed and dated with name clearly printed
 Proof of Anti-money laundering (AML) certification on file with Presidential.
or
indicate if completed through LIMRA? Yes

New Agent

- License Information sheet
 IRS form w-9
 2 copies of WA agreement with correct compensation level indicated. Signed and dated with name printed clearly
 Copy of current personal and/or corporate license
 Applicable state appointment fee
 Memo225_AML-Policy signed and dated with name clearly printed
 Proof of Anti-money laundering (AML) certification
or
indicate if completed through LIMRA? Yes

PRESIDENTIAL LIFE INSURANCE COMPANY

NYACK, NEW YORK

INSTRUCTIONS FOR AGENTS/BROKERS

BE SURE TO ASK ALL QUESTIONS AND RECORD THE ANSWERS IN DARK INK. DO NOT USE PENCIL. If, for some reason, a question is not applicable, please indicate that on the application. If an answer needs to be changed, DO NOT USE WHITE OUT. Put ONE line through the incorrect answer and insert the correct information.

All corrections MUST be initialed by the Proposed Insured. Make sure the application is properly dated, the city and state where it was completed are recorded, and that ALL of the necessary signatures are in place before the application is submitted. We will not accept an application that is completed on a photocopy or facsimile.

CONDITIONAL RECEIPT. Give the Conditional Receipt to the applicant in exchange for premium payment. Do not take any money unless you give the applicant the Conditional Receipt. You do not have any authority to alter or waive the conditions set forth in the Receipt.

If the Conditional Receipt is given, the first modal premium (2 months premium for check-o-matic) for the plan and amount of insurance which may become effective prior to policy delivery must be collected. However, no payment may be taken: (1) if the amount of coverage being applied for in this application **plus** the amount of any insurance and ADB previously issued or applied for with the Company exceeds \$500,000, (2) if the preliminary quote is other than Preferred or Standard, or (3) if the insurance age of the Proposed Insured exceeds 70.

Be sure the applicant understands the terms of the Conditional Receipt, in particular, the "CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY."

With the premium must be paid by check or money order. With the check or money order must be made payable to Presidential Life Insurance Company ONLY. Full amount collected must be entered in Question 9 of the Part I application.

IMPORTANT: If money is not received with the application, the Conditional Receipt must not be detached from the application.

APPLICATION FOR INSURANCE

PRESIDENTIAL LIFE INSURANCE COMPANY
69 Lydecker Street, Nyack, New York 10960

CONDITIONAL RECEIPT

This receipt is to be issued only if payment is made at the time the application is signed; otherwise, it must not be detached.

Unless the conditions specified in Paragraph "FIRST" are fulfilled exactly, no insurance will become effective prior to policy delivery. Neither the agent/broker nor the medical examiner is authorized to alter or waive these conditions.

Received from _____ the sum of \$ _____ in connection with this application for life insurance to Presidential Life Insurance Company of New York. This receipt bears the same date as the application.

FIRST. CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. If the following conditions are fulfilled exactly:

- (a) All medical examinations and tests, including X-rays and EKG's, initially required by published Company rules must be completed within 45 days after the date of this receipt and received at the home office within 60 days after such date.
- (b) An amount equal to the first modal premium for the amount of insurance which may become effective prior to policy delivery must be received with the application.
- (c) On the date that insurance becomes effective in accordance with the provisions of this receipt, each person to be covered must be insurable on a preferred or standard basis for the plan and the amount of insurance applied for without modification and at the rate of premium paid.

then insurance as provided by the terms and conditions of the policy applied for and for an amount not exceeding that specified in Paragraph "SECOND" will become effective on the latest of the following dates: (a) the date of Part I of this application; (b) the date that the last of the medical examinations and tests that were initially required by published Company rules is completed; and (c) the Date of Issue, if any, requested in the application. Any insurance applied for as alternate or additional to the plan and amounts of insurance applied for in the application will not become effective under this conditional receipt.

SECOND. LIMITS PROVISION: MAXIMUM AMOUNT OF INSURANCE THAT MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. The total amount of life insurance and accidental death benefits which may become effective prior to policy delivery will not exceed \$500,000. This amount includes any insurance and ADB currently being applied for in the Company.

THIRD. RETURN OF AMOUNT REMITTED. The sum paid in exchange for this receipt will be returned upon demand and surrender of this receipt and no insurance will become effective if: (a) all of the conditions specified in Paragraph "FIRST" are not fulfilled exactly; (b) the Company declines the application; (c) the Proposed Insured dies by suicide before the policy is delivered; or (d) the application contains any material misrepresentation(s). This sum will also be returned upon written request received at the home office before the policy is delivered.

This receipt is not valid unless signed by the Proposed Insured and the owner; if different, and the agent/broker who receives payment. **MAKE CHECK OR MONEY ORDER PAYABLE TO PRESIDENTIAL LIFE INSURANCE COMPANY. DO NOT MAKE CHECK OR MONEY ORDER PAYABLE TO THE AGENT/BROKER OR LEAVE THE PAYEE BLANK.** Any check or money order given in payment must be honored on the first presentation for payment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its home office in Nyack, New York. Give the name of the agent/broker; date and amount paid.

I (We) have read this receipt and understand the CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY (Paragraph "FIRST").

Signed at _____ this _____ day of _____, 20 _____

Proposed Insured

Signature of Agent/Broker

Owner (if other than Proposed Insured)

PRESIDENTIAL LIFE INSURANCE COMPANY

Nyack, NY 10960

**APPLICATION - PART I
(PLEASE PRINT OR TYPE)**

<p>1. FULL NAME OF PROPOSED INSURED <input type="checkbox"/> M <input type="checkbox"/> F (Women, give maiden name.)</p>	<p>13. PURPOSE OF INSURANCE</p>												
<p>2. RESIDENCE ADDRESS: Give No., Street, City, State, Zip Code</p> <p>Phone Nos.: Home () Work () How long at this address? _____ Previous addresses, within past 5 years.</p>	<p>14. a. OWNER (If other than Proposed Insured, give the following information.) Full Name: Address: Relationship to Proposed Insured: Soc. Sec. or Tax ID No.: Owner is <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Trustee (Give name of trust and date of trust agreement)</p> <p>b. CONTINGENT OWNER Full Name: Soc. Sec. or Tax ID No:</p>												
<p>3. OCCUPATION: Describe Duties: Name of Employer: Business Address:</p>	<p>15. BENEFICIARY: Give full name, address, date of birth, and relationship to Proposed Insured. Right to change Beneficiary is reserved to the Owner unless otherwise indicated</p> <p>PRIMARY: _____ _____ _____</p> <p>CONTINGENT: _____ _____</p>												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">4a. DATE OF BIRTH Month Day Year</td> <td style="width: 50%; padding: 5px;">4b. AGE NEAREST BIRTHDAY</td> </tr> <tr> <td style="padding: 5px;">5. STATE/COUNTRY OF BIRTH</td> <td style="padding: 5px;">6. SOC. SEC. NO.</td> </tr> </table>	4a. DATE OF BIRTH Month Day Year	4b. AGE NEAREST BIRTHDAY	5. STATE/COUNTRY OF BIRTH	6. SOC. SEC. NO.	<p>16. a. ALL INSURANCE IN FORCE ON LIFE OF PROPOSED INSURED (If NONE, so state.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">COMPANY</th> <th style="width: 25%;">AMOUNT</th> <th style="width: 25%;">ACC. DEATH</th> <th style="width: 25%;">ISSUE YR.</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	COMPANY	AMOUNT	ACC. DEATH	ISSUE YR.				
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COMPANY	AMOUNT	ACC. DEATH	ISSUE YR.										
<p>7.a. PLAN AND AMOUNT (Indicate Option 1 or 2, if applicable)</p>	<p>b. Which policies have a Business as Owner and/or Beneficiary? (If NONE, so state.)</p>												
<p>7.b. Complete only if applicable for plan applied for: Planned Periodic Premium: \$ _____ Lump Sum Payment: \$ _____ RIDERS: <input type="checkbox"/> WAIVER <input type="checkbox"/> OTHER:</p>	<p>17. SEND PREMIUM NOTICES TO: <input type="checkbox"/> Residence <input type="checkbox"/> Business <input type="checkbox"/> Owner (If other than Proposed Insured) If more than One Owner, give name and address of the one Owner who should receive the original notice: _____ _____ Other: _____</p>												
<p>8. MODE OF PREMIUM PAYMENT: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Check-o-matic <input type="checkbox"/> Single</p>	<p>18. SPECIAL REQUESTS</p>												
<p>9. AMOUNT REMITTED WITH THIS APPLICATION (In exchange for Conditional Receipt: \$ _____</p>													
<p>10. AUTOMATIC PREMIUM LOAN: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>													
<p>11. RATED CLASS: Issue Rated Class, if applicable. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>													
<p>12.a. Do you currently use tobacco in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please answer b. or c. below, whichever is appropriate.) b. If YES, indicate form(s) used; check all that apply. <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other (describe): _____ Give frequency of use for all forms checked above. For cigarettes and cigars, give number per day. c. If NO, check whichever is appropriate. <input type="checkbox"/> Never used <input type="checkbox"/> Quit: give mo. _____ yr. _____</p>													

(CONTINUED ON NEXT PAGE)

	YES	NO		YES	NO
19. Has any company or society declined to issue, reinstate, or renew a policy; offered a rated or modified policy; or postponed or canceled any insurance on your life?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have you in the past 2 years engaged in, or do you expect to engage in, hang gliding, flying ultra lights, racing (automobile, go-karts, midgets, cycle, boat, snowmobile), or diving (skin, scuba, sky)? If YES, complete Avocation Questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>
20. Is any application or informal inquiry on your life or health pending in any other company or society, or have you ever withdrawn such an application or informal inquiry?	<input type="checkbox"/>	<input type="checkbox"/>	24. In the past 3 years, have you been convicted of, pleaded guilty or no contest to: a. two or more moving violations and/or accidents? b. driving under the influence of alcohol and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
21. Is this insurance intended to replace or change any existing insurance, including annuities, in any company or society?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have you ever been convicted of a felony or misdemeanor?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you intend to fly other than as a passenger on a commercial airline or have you flown other than as a passenger on a commercial airline in the past 2 years? (If YES, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	26. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>
			27. Have you any intention of traveling and/or residing outside the United States?	<input type="checkbox"/>	<input type="checkbox"/>

28. REMARKS: If answer to questions 19, 20, 21, 22, 23, 24, 25, 26, and/or 27 is YES, please explain.

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.

I represent that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief. I agree that: (1) the entire contract will consist of this application and the policy issued in response to it; (2) no agent of the Company is authorized to: (a) make or modify contracts; (b) waive any rights or requirements of the Company; or (c) waive any information requested by the Company; and (3) **except as provided in the Conditional Receipt, if issued, no insurance will take effect unless: (a) the policy is delivered to the Owner; (b) the first modal premium is paid; and (c) there has been no change since the date of this application in the insurability of all persons proposed for insurance or in any of the answers to the questions on this application.** I acknowledge receipt of the Notice to Proposed Insured.

If I am applying for an indeterminate premium plan, I understand that: (a) the premium for such plan is guaranteed for the initial guarantee period, and, after such period, the current annual premium is not guaranteed and may change; and (b) the premium will never exceed the specified maximum.

Signed at _____ this _____ day of _____ 20____
City and State

Proposed Insured _____ Sign name in full Applicant/Owner _____
If other than the Proposed Insured-Sign name in full

Licensed Agent _____ Sign name in full

AGENT'S CERTIFICATE

Is this insurance intended to replace other insurance? Yes No

I HEREBY CERTIFY that I personally solicited and secured this application and except as indicated above, no one else is to have any share in the agent's commission thereon.

This application was solicited and written within my territory by a duly licensed agent of my agency.

Agent's Signature _____

GA's Signature _____

Code No. _____

Code No. _____

PRESIDENTIAL LIFE INSURANCE COMPANY

69 Lydecker Street, Nyack, New York 10960

**APPLICATION - PART II MEDICAL HISTORY (COMPLETE IF INSURANCE MAY BE CONSIDERED WITHOUT A MEDICAL EXAMINATION.)
PLEASE PRINT**

AGENT/BROKER'S INSTRUCTIONS

ALL QUESTIONS MUST BE ANSWERED. If, for any reason, a question is not applicable, please indicate that on the application. If an answer needs to be changed, DO NOT USE WHITE OUT. Put ONE line through the incorrect answer and insert the correct information. ALL corrections MUST be initiated by the Proposed Insured.

FULL NAME OF PROPOSED INSURED	DATE OF BIRTH Month Day Year	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER -- --
-------------------------------	---------------------------------	--	---------------------------------

1.a. List names and addresses of all health care professionals and professional health care treatment facilities providing care, treatment, advice, or consultations during the past five (5) years and give date(s) and reason(s). If NONE, state None. _____

b. What advice, treatment, and/or medication was given? If NONE, so state. _____

c. Are you currently under observation or treatment or are you taking any medication? YES NO If YES, explain. _____

d. Have X-rays, electrocardiograms, blood studies, or other diagnostic tests, excluding any study or test for exposure to the AIDS virus (HIV), been done during the past FIVE years? _ YES NO _ If YES, when, why, by whom, and results? _____

e. Have you been advised to have any diagnostic test (excluding any test for exposure to the AIDS virus (HIV)), medication, treatment, hospitalization, or surgery which was not completed? YES NO If YES, explain. _____

2. Have you ever had or do you now have any of the following?

Please check the appropriate box.

- | | YES | NO |
|--|--------------------------|--------------------------|
| a. Disorder of eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dizziness, fainting, convulsions, head injury, headaches, speech defect, paralysis, stroke, tremors, muscle weakness, depression, other mental or nervous disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, tuberculosis, pneumonia, emphysema, asthma, or chronic respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest pain, angina, palpitations, high blood pressure, rheumatic fever, or other severe infection, heart murmur, heart attack, varicose veins, phlebitis, or other disorder of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, liver, intestines, pancreas, gallbladder, or spleen? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sugar, albumin, blood or pus in urine, stone, or any other disorder of the kidney, bladder, prostate, or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes, goiter, thyroid, or other endocrine disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Lupus erythematosus, Multiple Sclerosis, neuritis, arthritis, gout, or disorder of the muscles or connective tissue? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any disorder of the bones, including the spine, back and joints, deformity, lameness, or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder of skin, breast or lymph glands, cyst, tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Anemia, hemophilia, bleeding tendency, or other disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Chronic or unexplained fatigue, malaise, loss of appetite, weight loss, diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions, unexplained swelling of the lymph glands, Kaposi's Sarcoma, or Pneumocystis Carinii Pneumonia? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Any sexually transmitted or venereal disease? | <input type="checkbox"/> | <input type="checkbox"/> |

DETAILS of YES answers. (Identify question number. Circle applicable items: include dates, diagnosis, duration, treatment, and names and addresses of ALL health care professionals and treatment facilities consulted.) Attach an additional sheet if more space is required for information.

(CONTINUED ON NEXT PAGE)

Page 3

	YES	NO
3. a. Height _____ ft. _____ in. Weight _____ lbs.		
b. Have you had any change in weight in the past 12 months? If YES, how much? Gain _____ lbs., Loss _____ lbs. Reason for change _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been diagnosed by a member of the medical profession as having, or received treatment from such member for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. a. Do you currently take or use any narcotic, stimulant, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? If YES, give name(s), form(s), amount, frequency and length of use and age first used, for each drug and/or substance used.	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever taken or used any of the drugs/substances listed in 5.a. or any other drug, except as prescribed by a physician? If YES, give name(s), form(s), amount, frequency and length of use, and date use was discontinued, for each drug and/or substance used.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever:		
a. Used alcoholic beverages? If YES, how often, how many ounces, and for how many years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been advised to reduce or discontinue the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
d. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug related problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
8. To the best of your knowledge are you now pregnant? If YES, how many months? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Family History: Is there a history of diabetes, heart disease, high blood pressure, cancer, kidney disease, tuberculosis, alcoholism, mental illness, suicide, or any inherited disease?	<input type="checkbox"/>	<input type="checkbox"/>
	Age if Living	Age at Death
Father		Cause of Death
Mother		
Brothers and Sisters	No. Living	
	No. Dead	

DETAILS of YES answers. (Identify question number. Circle applicable items: include dates, diagnosis, duration, treatment, and names and addresses of ALL health care professionals and treatment facilities consulted.) Attach an additional sheet if more space is required for information.

I represent that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief.

Signed at _____ this _____ day of _____, 20 _____

Agent/Broker Proposed Insured

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization.

COMPANY: Presidential Life Insurance Company
INSURANCE SUPPORT ORGANIZATIONS: MIB, Inc. and/or Consumer Reporting Agency
BUREAU: MIB, Inc.
AUTHORIZATION: Authorization to Obtain and Disclose Information

I understand that the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organizations; (7) financial source; and (8) employer, to give the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits. These facts may include details of alcohol and/or drug use, abuse, and/or treatment. The Company and its reinsurers will use the information in order to determine whether I am insurable.

Those parties named in the first paragraph of this Authorization, excluding insurance support organizations, may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. Insurance support organizations may disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law.

This Authorization will be valid for two years after the date of signing. I understand that I or my authorized representative may request to receive a copy of this Authorization. I authorize the Company to procure an investigative consumer report, if required.

If a minor child is proposed for coverage, these statements are made by the person authorized (parent or legal guardian) to act on behalf of the minor child named in the application.

Signed at _____ this _____ day of , _____ 20_____

Signature of Proposed Insured

Signature of Parent or Legal Guardian, if applicable.

.....
(Please detach and give to Proposed Insured)
NOTICE TO PROPOSED INSURED - PART I

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the Company within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and, if so, you will be advised of the name and address and telephone number of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely primarily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report by contacting the consumer reporting agency as explained in the Federal Fair Credit Reporting Act Notice.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of Presidential Life's and your agent/broker's information practices. If you would like to receive a more detailed explanation of those practices, please send your request to the Director of Underwriting, Presidential Life Insurance Company, 69 Lydecker Street, Nyack, NY 10960.

**PERSONAL STATEMENT SUPPLEMENT TO APPLICATION TO
PRESIDENTIAL LIFE INSURANCE COMPANY
TO BE COMPLETED AND SIGNED IN ALL CASES**

Name of Proposed Insured _____ Date of Birth _____

1. Personal Finances:

Total Assets \$ _____
Total Liabilities \$ _____
Net Worth \$ _____

Income:
Earned \$ _____
Unearned \$ _____

2. What is the purpose of this insurance? _____

3. Have you or your company ever filed for bankruptcy? YES NO
If yes, provide full details _____

4. Except for traffic violations, have you ever been arrested? YES NO
If yes, provide full details as to nature and final disposition. _____

5. Complete this section only if business insurance is applied for.

a) Business Finances:

Total Assets \$ _____
Total Liabilities \$ _____
Net Worth \$ _____

Net Profit after Taxes:
Last Year \$ _____
Previous Year \$ _____

b) Is the business a Corporation, Partnership or Proprietorship? (Circle One)

c) How long has the business been established? _____

d) What is the nature of the business? _____

e) What is your percentage ownership of this firm? _____

f) Is there business insurance applied for or in force on other key members of this firm? YES NO
Provide details: _____

Signed at _____ this _____ day of _____, 20_____

Signature of Proposed Insured

Signature of Applicant/Owner

NOTICE TO PROPOSED INSURED - PART II

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. Presidential Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-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 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Presidential Life Insurance Company, 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 website at www.mib.com. 9/08

General Notice

In the course of evaluating and handling each application for insurance, the Company relies primarily on the information provided by you; therefore, you must provide true, complete, and accurate information on the application. Although the Company does not always do so, it may also seek information from other sources. Any information that it obtains from these sources may not be current or complete or accurate however. Consequently, you **must** inform the Company, prior to delivery of any policy, of any change to any answer on your application. Please review your application for accuracy after all parts have been completed. Any policy that is delivered to you may be contested for a period of two years after the date of issue; this period is referred to as the contestable period. A contest may result if your application is incomplete or if it contains false statements or misrepresentations. Any policy that is delivered to you may be voided and coverage or benefits may be lost as the result of a successful contest within the contestable period. Also, be sure to inform the Company of any changes to any answers on your application that occur before any policy is delivered. In so doing, you can facilitate the issue of your policy and the commencement of coverage.

APPENDIX A

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured _____ Age _____ Sex _____

*Name of Agent preparing disclosure _____

*Agent home or agency address _____

*Telephone number of Agent _____

Name of Insurer PRESIDENTIAL LIFE INSURANCE COMPANY

Home Office Address of Insurer (City & State) 69 LYDECKER STREET NYACK, NEW YORK 10960

Direct all correspondence to (Insurer's home, executive or administrative office) INSURER'S HOME OFFICE

	Descriptive Title of Coverage	Face Amount of Coverage (1)	Annual Premium
		If not applicable Description of Coverage	If not Known, Premium for Mode Quoted (2)
*Policy	_____		
*Riders	_____		
*Supplemental Benefit(s) (Built into policy)	_____		The cost is included in the premium for the policy

*(1) The face amount of coverage of the _____ changes as follows _____

*(2) The premium for the _____ changes; the ultimate _____ premium will be _____ at _____ policy year (age) [or representative _____ premiums will be _____ and _____, and the ultimate _____ premium will be _____ at _____ and _____ and _____ policy years (ages) respectively].

Total (Initial) premium _____ for the policy and rider will be _____.

*Retirement Income. Your policy is designed to pay a guaranteed retirement income of \$ _____ starting at _____ for _____ but not less than 10 years.

*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 (or face amount). *You may borrow against this cash value at an annual _____ % loan interest charge.

Number of Years Policy Has Been in Force	5	10	20	age 45
Total Accumulated Cash Value Per \$1,000 (or Total Face Amount)				

*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 (or Face Amount)	NOT APPLICABLE	

*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 prospective 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.

*If applicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable".

**PENNSYLVANIA
APPENDIX A DISCLOSURE STATEMENT
DELIVERY RECEIPT**

Pursuant to Pennsylvania Regulations, Title 31, Part IV, Chapter 83:

The agent shall submit to the insurer with or as a part of the application for life insurance a statement, signed by him or her, certifying that a written disclosure statement was given no later than the time that the application was signed by the applicant.

AGENT CERTIFICATION

I hereby certify that I provided the applicant with an Appendix A Disclosure Statement no later than at the time the application for life insurance was signed by the applicant.

Name of Applicant (print)

Signature of Agent

Date

Name of Agent (print)

Presidential Life Insurance Company Nyack, NY 10960
1-800-926-7599 or 1-888-PRES LIF
www.presidentiallife.com



Bulletin

REMINDER: PENNSYLVANIA LIFE SALES

Title 31, Part IV, Chapter 83 of the Pennsylvania Insurance Regulations requires that every Pennsylvania resident applying for a life insurance policy must receive an Appendix A Disclosure Statement presenting basic information about the policy for which he or she is applying. The Disclosure Statement must be provided no later than at the time the application for the policy is signed.

Accompanying this reminder are:

- A copy of the approved Appendix A Disclosure Statement to be used with all Presidential life insurance sales in the State of Pennsylvania, and
- A copy of the Presidential Life Pennsylvania Life Insurance Appendix A Disclosure Statement Delivery Receipt

A copy of the Pennsylvania Life Insurance Appendix A Disclosure Statement Delivery Receipt must accompany all Pennsylvania-resident life insurance applications sent to the Home Office. The form should be appropriately dated and signed by the agent.

Agency

Presidential Life Insurance Company Nyack, NY 10960
1-800-926-7599 or 1-888-PRES LIF
www.presidentiallife.com



**APPLICATION TO
PRESIDENTIAL LIFE INSURANCE COMPANY
NYACK, NEW YORK 10960**

THIS APPLICATION IS TO BE ATTACHED TO AND MADE A PART OF THE POLICY

Proposed Insured _____
Print Name in Full

Address _____
Street

_____ City State Zip

1. Date of Birth _____ Age Nearest Birthday _____ Sex Male Female
Month Day Year

2. Plan of Insurance -- Graded Benefit Life Policy Amount of Insurance \$ _____

3. Beneficiary - Print Full Name and Relationship
Primary _____
Contingent _____

Unless otherwise specified under remarks the interest of beneficiaries and owners are to be governed by the company's standard policy provisions.

4. Applicant/Owner if other than Proposed Insured _____
Address _____
Street
_____ City State Zip

5. Premiums are to be paid Annually Semi Annually Quarterly ABC
Amount paid with this application \$ _____

6. Is there any other life insurance in force on a guaranteed issue basis? Yes No
(If "Yes," list name of insurance company and amount of insurance.)

7. Does Applicant intend to drop or change any existing individual life insurance policy or annuity on your life in favor of the insurance now applied for? Yes No
(If "Yes," list, by insurance company & policy number, the policy or policies to be dropped or changed.)

8. The applicant understands that the policy has a reduced death benefit for _____ years.

9. Remarks _____

I hereby state that the answers given above are true to the best of my knowledge and belief.

The policy applied for shall not be in force until it has been delivered and the first premium paid during the insured's lifetime.

Signed at _____ this _____ day of _____ 20 _____
City and State

Proposed Insured _____ Applicant/Owner _____
Sign name in full If other than the Proposed Insured-Sign name in full

Licensed Agent _____
Sign name in full

AGENT'S CERTIFICATE

Is this insurance intended to replace other insurance? Yes No

I HEREBY CERTIFY that I personally solicited and secured this application and except as indicated above, no one else is to have any share in the agent's commission thereon.

This application was solicited and written within my territory by a duly licensed agent of my agency.

Agent's Signature _____

GA's Signature _____

Code No. _____

Code No. _____

PRESIDENTIAL LIFE INSURANCE COMPANY

NYACK, NEW YORK 10960

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

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 omission 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

DATE

AGENT'S SIGNATURE

DATE

Original to Applicant

Copy to Home Office

Copy to Agent

RPL-PA(L)

To be used with life replacement

PRESIDENTIAL LIFE INSURANCE COMPANY



DIRECT DEBIT AUTHORIZATION

I hereby authorize Presidential Life Insurance Company, ID Number 132570714 to initiate debit entries from the account named below to pay premiums on the policy number below. Presidential Life Insurance Company is also authorized to initiate, if necessary, adjustments to the account for any debit or credit entries made by the company in error.

POLICY # _____ INSURED _____

BANK NAME _____

BANK ADDRESS _____
STREET CITY STATE ZIP

TRANSIT/ABA #

ACCOUNT # _____

Select one: Checking Savings

Date of Monthly Withdrawal (1st thru 28th) _____

NAME(s) on account _____

This authority is to remain in full force and effect until Presidential Life receives written notice of its termination signed by the account holder(s) in such time and in such manner as to afford the company and the depository a reasonable opportunity to act on it.

Signature of account holder Date

Signature of joint account holder (if applicable) Date

PLEASE ATTACH A VOIDED CHECK
OR
A DEPOSIT TICKET WITH A MICROENCODED ACCOUNT NUMBER

◆◆◆ PLEASE VERIFY ALL ACCOUNT INFORMATION WITH YOUR BANK ◆◆◆

PRESIDENTIAL LIFE INSURANCE COMPANY
69 LYDECKER STREET, NYACK, NEW YORK 10960

1-800-926-7599 OR 1-888-PRES LIF
www.presidentiallife.com