



**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</i>		<i>City</i>	<i>State</i>	<i>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</i>		<i>City</i>	<i>State</i>	<i>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 other insurance coverage in force?.....  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. 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**—If this question is answered YES, the Proposed Insured will be considered for the Modified 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

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

- 1. 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
- 2. 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
- 3. 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, B and C 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 - Graded life insurance for the first two years; not in full benefit until three years  
 Modified Benefit Whole Life - Reduced death benefit for two years

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 subject to a substantial civil penalty where and to the extent allowed by state law.**

Signed at \_\_\_\_\_  
City State

on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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 other insurance coverage in force?.....  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 and MODIFIED 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	224.31	115.64	150.81
54	53.46	70.18	45.51	61.37	75	167.58	243.97	125.25	161.91
55	55.62	73.41	47.01	63.53	76	182.62	266.18	136.37	175.04
56	57.77	76.70	48.56	65.64	77	199.28	290.48	148.73	189.77
57	59.93	80.04	50.14	67.70	78	217.74	317.29	162.44	206.12
58	62.21	83.61	51.82	69.83	79	238.21	347.01	177.65	224.13
59	64.73	87.57	53.66	72.16	80	260.90	380.02	194.47	243.80
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

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](http://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.





**IMPORTANT NOTICE**

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

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

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

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

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

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

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

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

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

The existing policy or contract is being replaced because:

\_\_\_\_\_

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

_____	_____
<i>Applicant's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>
_____	_____
<i>Producer's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>

**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.**



I do not want this notice read aloud to me. \_\_\_\_\_ (*Applicant must initial only if they do not want the notice read aloud.*)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

### **PREMIUMS**

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

### **POLICY VALUES**

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

### **INSURABILITY**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

### **IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY**

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

### **IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT**

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

### **OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS**

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (*See your tax advisor.*)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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**IMPORTANT NOTICE**

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

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

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

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

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

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

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

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

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

The existing policy or contract is being replaced because:

\_\_\_\_\_

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

_____ <i>Applicant's Signature and Printed Name</i>	_____ <i>Date (MM/DD/YYYY)</i>
_____ <i>Producer's Signature and Printed Name</i>	_____ <i>Date (MM/DD/YYYY)</i>

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**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.**



