

Part I – Personal Information

Title: Mr. Mrs. Miss Ms. Other _____

Applicant Last Name First Name / Middle Name

Birthdate (mm/dd/yyyy) Age yrs Social Security Number Gender Male Female

Street Address

City State Zip

Daytime Phone: () - - Evening Phone: () - -

Part II – Policy Information

Face Amount \$,

Level Benefit (**Legacy I**) Increasing Benefit (Graded*) (**Legacy II**)

Accidental Death Rider Return Of Premium Benefit (Modified*) (**Legacy III**)

Nursing Home Waiver of Premium Rider ** Reduced Death Benefit for first 2 Years*

Will this policy replace an existing life insurance policy or annuity (if yes, complete Replacement Notice)? Yes No

In the past 12 months, have you smoked cigarettes or used any other tobacco products? Yes No

Part III – Beneficiary Designation

Primary Beneficiary Relationship to Applicant

Street Address

City State Zip

Contingent Beneficiary Relationship to Applicant

Street Address

City State Zip

Owner, if other than Applicant Relationship to Applicant

Street Address

City State Zip

Part IV – Alternate Payor

I understand that I may choose a person other than myself to receive notice of lapse or termination of my insurance policy for nonpayment of premium. This person will not be notified until thirty (30) days after a premium is due and unpaid.

- I elect NOT to designate an additional person to receive notification.
- I elect to designate an additional person.

First Name - MI - Last Name

Phone

Address

City

State

Zip

Part V – Premium Payment & Administration

INITIAL Premium Paid: Requested Effective Date (if other than Application Date)

\$,. -- (mm-dd-yyyy)

RENEWAL: Direct Bill

Bank Draft Account Type: Checking Savings

Mode: Annual Semi-Annual Quarterly Monthly Bank Draft

I authorize Bank Draft payments.

Bank Routing # (9 digits):

Bank Account # (do not include check #):

Select Draft Date:

Bank Name: _____

Name(s) of Depositor(s): _____

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on or shortly following the selected draft day requested above (never before).

Payor if not Applicant: List Bill Other _____

Name

Address

City

State

Zip

Automatic Policy Loan:

Yes No

Payment Plan:

Single Pay

10-Pay

Continuous

Part VI – Agreement & Acknowledgement

As part of the Life Insurance Application process, Equitable Life & Casualty has certain information that you should review as part of your decision to purchase our policy. Please indicate your receipt of this information:

- Life Buyers Guide
- Replacement Notice, if applicable
- Notice of Information Practices and Privacy Policy

I FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand the Company will conduct a telephone interview with me regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Signed at (City and State): _____ Date: --

Signed Applicant: _____ Owner (if not applicant) _____

Witnessed by Agent: _____ Agent Number _____

Send policy to: Applicant Agent

3

Part VII – Agent Supplement

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | All questions must be completed. |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Did you personally interview the applicant and witness all signatures? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. State the name and relationship of any other person present when this application was taken. Name _____ Relationship _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Did you review the application for correctness and any omissions? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Did the applicant(s) review the application for correctness and any omissions? |

Agent #1 Signature _____ Date _____

Agent #2 Signature _____ Date _____

| | | |
|------------------------------|----------------------|----------------------|
| Agent #1 Name (please print) | Agent # | Split % |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|------------------------------|----------------------|----------------------|
| Agent #2 Name (please print) | Agent # | Split % |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Equitable Life & Casualty Insurance Company ("Equitable") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that Equitable may: **1)** underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with Equitable.

For a period of 120 days from the date of this Authorization I authorize my Equitable Agent to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **Equitable at 3 Triad Center, Salt Lake City, Utah 84180, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Equitable has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Equitable may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I will receive a copy of this authorization.

Name of Applicant (please print)

Signature of Applicant or Personal Representative

Date of Birth

Date

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

Agent Checklist

The following Checklist is intended as a helpful reminder to you of the Forms to be submitted with an Application. Applications submitted without ALL required Forms delay the underwriting process until the Forms are submitted. *Forms to be submitted to the Home Office are marked "Return to Company" and have a bar code in the middle bottom area. All forms to be left with the Applicant are marked "Leave with Applicant" in the middle bottom.*

Forms for the Home Office

Please print clearly.

- Application** (A-LF 07) — All Sections must be completed
- Health Information Authorization** (HHA-04) — for the release of health information
- Replacement Notice** (LRN-(01)) — complete both Notices - when not a replacement case, destroy both forms

Forms for the Applicant

- Notice of Information Practices & Privacy Policy
- Receipt
- Replacement Notice (if needed) (LRN-(01))

Other Items to Remember

Additional Forms can be ordered by calling 1-800-352-5125 or by visiting our exclusive agent website: www.EquiLine.com.

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES *(continued)*

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 our 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?

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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 the withdrawal or surrender of or by borrowing 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 interests. 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 the back 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 NUMBER | INSURED OR ANNUITANT | REPLACED (R) OR FINANCING (F) |
|----|--------------|---------------------------|----------------------|-------------------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

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 documents 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:

Applicant's Signature Applicant's Printed Name Date

Producer's Signature Producer's Printed Name Date

I do not want this notice read aloud to me (Applicants must initial only if they do not want the notice read aloud.)

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NOTICE OF OUR INFORMATION PRACTICES AND PRIVACY POLICY

With your application for insurance we receive personal information about you. You also authorized us to collect your health information. We keep and protect all such information as confidential and do not disclose it to any other persons, entities or organizations unless authorized by you in writing or as allowed or required by law.

Information We Collect And Receive

Personal information we receive about you comes directly from you, such as your name, address, birth date, Social Security number, telephone number, or e-mail address. Health (medical) information about you comes from you and your health care providers (doctors, clinics, hospitals, laboratories, etc.) based on your written Authorization. We may also review information about you on file with the MIB Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

What We Do With This Information

Your personal information is entered in our system to identify you as our customer. Other uses of your personal and health information include underwriting your application for insurance and assisting you in a claim for benefits. Your Equitable agent, as our business associate, may have access to your health information during the underwriting process, as authorized by you, and access to your personal information for assistance with your insurance needs.

Under our established procedures, if upon the consideration of your medical information we determine you do not meet our underwriting guidelines for the issuance of a policy, the medical reason(s) for a declination of coverage may be disclosed to the person or entity (usually your doctor) who maintains your medical information. Your doctor can then discuss with you, through a private consultation, the medical reason(s) for our decision.

How We Protect This Information

Our employees and agents are required to keep your personal and health information confidential. Our intention is to request or access only the minimum amount of information necessary. We maintain all your personal or health information in a secured database, with security and procedural measures in place, in compliance with federal law, to safeguard your protected information and alert us if and when unauthorized access is attempted.

We do not disclose your personal or health information with any nonaffiliated third party (person, entity or organization) without your written permission, unless allowed or required by law. Under no circumstances will any information be disclosed to any nonaffiliated party for marketing purposes, such as telemarketing, direct mail or electronic mail marketing.

How You Can Access This Information

Write to us and request copies of the personal information we have about you in our records. You can also find out who we have disclosed this information to and for what reason. If you believe any personal or health information we have about you is incomplete, inaccurate or incorrect, you have the right to request that we correct or delete it. If your request concerns health information we received from a doctor, hospital or other medical provider, we will refer you to that person or entity. You may, in a private consultation with them, have the necessary corrections made to your health information and sent to us.

The MIB Inc.

Information regarding your insurability will be treated as confidential. Equitable Life & Casualty Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB, toll free, at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of 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, MA 02184-8734.

Equitable Life & Casualty Insurance Company, or its reinsurers, may also release information in 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.

If you have any questions about this Notice, we can be contacted at:

Equitable Life & Casualty Insurance Company
3 Triad Center, Salt Lake City, UT 84180-1200
ATTN: Privacy Officer
Telephone (toll free): 1-800-352-5150

Leave with Applicant

Receipt

Receipt

Please Note: All premium checks must be made payable to Equitable Life & Casualty Insurance Company. Do not make checks payable to the insurance agent or leave the payee line blank.

Received from _____
the sum of \$ _____ for _____ months premium, with this applica-
tion. If for any reason the application is not approved and the policy is not issued, this premium
is to be refunded. No liability is created or assumed by the Company, except for refund of this
premium, until the policy applied for has been issued.

Dated _____, 20 _____

Agent's Signature

Equitable Life & Casualty Insurance Company, 3 Triad Center, Salt Lake City, UT 84180-1200

