



Aviva Life and Annuity Company
 P.O. Box 1555
 Des Moines, IA 50306-1555

**Agents Report
 for TeleApp
 Application**

1. a. Does the proposed insured have any life insurance or annuity contract(s) currently active with our company or any other company? Yes No
 (If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
 b. Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? Yes No

1035 Exchange (attach required forms) External Internal _____

2. I personally viewed all driver's licenses or other government issued photo identification documents. Yes No

3. Is proposed insured a U.S. citizen? Yes No If no, how long in U.S.? _____ Permanent resident? . . . Yes No

If not a U.S. citizen/permanent resident, type of Visa? _____

4. Does the proposed insured and owner speak and understand English? Yes No

5. Additional Alternate Amount \$ _____ Plan _____

6. What is the proposed insured's: Annual earned income \$ _____ Annual unearned income \$ _____ Net worth \$ _____

7. Remarks _____

8. If Married:

a. Spouse's name _____ b. Spouse's occupation _____

c. Amount of life insurance in force on spouse \$ _____ d. Spouse's annual earned income \$ _____

9. a. **If proposed insured is a minor dependent, complete for all brothers and sisters:**

Age	Sex	Amount of Life Insurance in Force

Age	Sex	Amount of Life Insurance in Force

b. Amount of life insurance in force on each supporting parent or legal guardian \$ _____

10. a. Purpose of insurance Business Personal Estate (If multi-purpose, give percentage of face or split the amount by purpose in remarks section below.)

b. If business: Deferred Comp Buy/Sell Split Dollar Key Person Premium Financing Mortgage Financing

Business net annual income \$ _____ Business net worth \$ _____

Proposed insured's business life insurance in force \$ _____ % of ownership _____

Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount in Force



AGENT'S CERTIFICATION

I certify that I saw and know the proposed insured(s) to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the applicant, that I know of no condition affecting the eligibility or insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. Other than policy-related information, I have given the proposed insured or owner(s) nothing of value in connection with this application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No. _____ Agency Name _____

List of all agents (please print)	Agent code#	Commission share

Signed at _____ Signed (writing agent) **X** _____ Date _____

Phone # _____ E-Mail _____ Fax # _____

Preferred mode of communication? Phone E-Mail Fax





Conditional Life Insurance Agreement

(In this receipt, "Company" refers to the insurance company named above.)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount on page 2 of the application, if the proposed insured is insurable at the rate applied for or better; or
 - b. \$100,000 or the amount on page 2 of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from _____ Payment in the Amount of \$ _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

The Proposed Insured is _____ Signature of Owner _____

Signed at _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK





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The Proposed Insured is _____ Signature of Owner _____

Signed at _____
City State Date Signature of Agent

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK



Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 4905
Des Moines, IA 50306-4905
Fax: 1-800/531-0038



Disclosure Notice to Proposed Insured

In this Disclosure, "Company" refers to the insurance company named above.
In this Disclosure, "You" and "Your" mean the Proposed Insured.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding Your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life 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 at 866-692-6901 (TTY 866-346-3642) if you are interested in such a disclosure. If you question the accuracy of information in MIB's file, you may contact the MIB information office in writing at Post Office Box 105, Essex Station, Boston, Massachusetts 02112 and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The Company or its reinsurers may also release information in its file to insurance support organizations, or to other insurance companies to whom You may apply for life or health insurance or to whom a claim for benefits may be submitted. Insurance support organizations include any person or entity that assembles or collects information about individuals primarily for the purpose of providing such information to an insurance company.

INVESTIGATIVE CONSUMER REPORT

In addition to requesting a report from MIB, as a part of the Company's underwriting process the Company may request an investigative consumer information report to confirm and supplement the information on Your application about Your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover Your mode of living, except as may be related directly or indirectly to Your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with You or Your family, friends, associates, or others with whom You are acquainted. If a consumer information report is requested, You may request to be personally interviewed if You can be contacted during normal business hours. An interview is normally conducted, but You are entitled to make a specific request. You may submit a written request asking to be notified if an investigative consumer report has been prepared. You may also request information on what organization prepared such a report and how to contact that organization.

The Company keeps such information reports confidential and uses them only to evaluate and underwrite Your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If the Company requests a report and the report has an adverse effect on Your insurability, the Company will notify You in writing and give You the name and address of the reporting company.

USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through such financial institutions, including insurance companies.

This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number or other tax identification number, and other information as deemed necessary, of all policy owners.**

INFORMATION PRACTICES

Personal information the Company obtains during the underwriting process is private and confidential, and the Company will not disclose it to other persons or organizations without Your written authorization except to the extent necessary to conduct the Company's business, or as permitted or required by law. The Company reserves the right to disclose medical information to a medical professional of Your choice and the right to arrange for an insurance support organization to disclose information on the Company's behalf.

Personal information that may be collected includes mental and physical health conditions, medical history, medical treatment, and information about Your general character, habits, hobbies or avocations, finances, employment, occupation, reputation, or marital



status. The information may be collected for the Company by the Company's employees, the Agent, and insurance support organizations that assemble information or prepare investigative consumer reports about You. Information may be collected from personal interviews or by telephone calls with You or Your family, neighbors, friends, business associates, and employers, also from public records, court documents, insurance support organizations and other insurance companies or insurance institutions. If there is a need to contact You by phone, a specially trained representative will call to verify or to ask for additional information relating to the underwriting of Your application.

DISCLOSURE OF INFORMATION AND RIGHT OF ACCESS TO INFORMATION

The Company may disclose personal information about You without prior authorization under certain circumstances. For instance, disclosure may be made to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for the Company, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may give information to accounting firms performing audits, governmental agencies reviewing Company practices, or attorneys hired to protect the Company's legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which You have applied for coverage or benefits. Information may be furnished to agents to aid them in providing adequate service to a policyowner. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing You of a medical problem of which You may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups which conduct studies about risk experience or medical backgrounds of insured lives. No medical record information or personal information relating to Your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

Upon Your written request, the Company will inform You of all persons or entities to whom the Company, the Agent, or any insurance support organization has released Your personal information during the 2 years prior to Your request.

You have a right of access to Your personal information that the Company has collected, and a right to know from what sources it was collected. You may submit a written request to the Company that includes Your full name, address, and policy number and reasonably describes the information desired. The Company will mail the information to You or You may review such personal information in person at one of the Company's offices. The Company will inform You of the nature and substance of the information within 30 days from receipt of the request. The Company will identify sources of information such as hospitals, clinics, doctors, or insurance support organizations. The Company will not identify sources of information where such information was obtained from individuals such as friends or neighbors. The Company will not provide access to information obtained in connection with or in anticipation of a claim for policy benefits, or as part of a civil or criminal proceeding.

You may request that the Company correct, amend, or delete personal information in whole or in part by making written request to the Company. Within 30 days from receipt of the request, the Company will inform You that the Company has either changed such information or the Company will communicate the reasons for not changing such information. If the Company does not make the requested change(s), You may then submit a written statement to the Company setting forth Your opinion regarding the information and/or the reasons why You disagree with the Company's position. All written communications will become part of the policy file.

In any case, the Company will provide either the corrected personal information, or Your request and statement, to all insurance support organizations with whom the Company has shared such information during the previous 7 years. The Company will also notify any specific persons or entities that You direct the Company to inform, who may have received such information during the previous 2 years.





Aviva Life and Annuity Company
P.O. Box 1555
Des Moines, IA 50306-1555

Informed Consent

Except for results of any testing of my blood, oral specimen, or urine for AIDS antibodies, I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the insurer named above (the Insurer) or its reinsurers or its authorized representatives any such information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I CONSENT to the drawing and testing of my blood, oral specimen, or urine for AIDS antibodies and AUTHORIZE disclosure of test results to me or the physician or health organization designated below, for a period of six months from the date shown below.

I, UNDERSTAND the information obtained by use of this Authorization and Consent will be used by the Insurer or its reinsurers to determine eligibility for insurance, or eligibility for benefits under an existing policy. Any information obtained will not be released by the Insurer or its reinsurers to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. Results of any testing for AIDS antibodies may only be released to the insurer, reinsurer, the Medical Information Bureau or those parties specifically indicated below.

I AGREE that this Authorization shall be valid

- (a) for six months from the date shown below only for the purpose of testing my blood, oral specimen, or urine for AIDS antibodies;
- (b) for 30 months from the date shown below, if signed in the course of making application for insurance coverage;
- (c) for the duration of a claim or the claims processing activity, if signed in the course of making a claim for insurance benefits under a life or disability policy;

and that a photographic copy of the Authorization shall be as valid as the original.

Name of the Party to Receive Test Results

Physician _____
 Address _____

County Health Organization

Applicant

_____ Date Signed

_____ Signature of Proposed Insured

_____ Signature of Joint Insured or Spouse

SEE INFORMATION ON THE BACK OF THIS PAGE

EXHIBIT 1
[OAR 836-50-250]

**HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT**

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

The HIV antibody test:

Before you consent to testing, please read the following important information:

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
 - a. **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
 - b. **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.An insurer may not rate or deny coverage on the basis of test results unless the rating or denial is based on a test protocol consisting of two positive ELISA tests confirmed by a Western Blot test.
4. **Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you or the physician or county health department that you designate.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, oral specimen or urine test may be reported to the Medical Information Bureau, a national insurance data bank, as a non-specific abnormality determined by the testing of blood, oral specimen or urine.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at 223-AIDS and outside the Portland area at 1-800-777-AIDS. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is 1-800-542-3104 or 1-503-373-1692.



Aviva Life and Annuity Company
 800/800-9882
 P.O. Box 1555
 Des Moines, Iowa 50306-1555

**Pre-Authorized Check
 (PAC) Authorization
 Form**

MUST BE COMPLETED IN FULL - (Please print or type all information except signatures. Please use black ink.)

Insured: _____
 Owner: _____ Telephone No. of Owner: (____)____-_____
 Owner's Address: _____ Address Change Requested:

CHECK APPROPRIATE BOX

TYPE OF REQUEST:

FIRST REQUEST FOR PAC PLAN (A check with receipt of funds is needed for initial premium payments. First or initial premiums cannot be drawn automatically.)

ADD TO EXISTING PAC UNDER POLICY # _____

CHANGE OF BANKS, ACCOUNT NUMBER, OR PREMIUM PAYOR - allow 15 days for change processing.

FOR USE ON NEW BUSINESS CASES ONLY:

REQUESTED BILLED AMOUNT (Universal Life Only) \$ _____

PLEASE INDICATE DAY 1st - 28th _____

PAC WILL BE THE SAME AS POLICY DATE UNLESS OTHERWISE INDICATED.

Completion of this Authorization DOES NOT provide coverage under a Conditional Life Insurance Agreement.

POLICIES TO BE INCLUDED IN THIS (PAC) PLAN

Policy Number	Insured's Name	Premium/Loan Repay Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION TO HONOR BANK WITHDRAWALS BY (Must be completed):

PREMIUM PAYOR (Print Name as Shown on Financial Institution Records) _____

Financial Institution Name _____ hereinafter referred to as "You"

Address _____

Telephone Number _____

Bank Routing No.

--	--	--	--	--	--	--	--	--	--

 Bank Account No. _____

9 numbers required

Checking account Savings account

The Company may assess a \$25 fee if any withdrawal authorized herein is dishonored for any reason.

I hereby request and authorize you to pay and charge to my account debit entries, including checks, drafts and other orders whether by electronic or paper means initiated on my account by the Company, to its own order. This authorization will remain in effect until revoked by me in writing in such time and in such manner as to afford you the Company a reasonable opportunity to act on it, and until you receive such notice, I agree that you shall be fully protected in honoring any such debit entry. In the event you comply with the above request and authorization, I agree that you may at any time cease your participation in and compliance with this request and authorization by giving thirty (30) days written notice to me and the Company.

I further agree that if such debit entry is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. I understand this form is a bank authorization only and there will be no charge to my account until and unless a policy of insurance is issued by the Company.

X _____ X _____
 (Signature of Premium Payor) (Additional signature if joint account)

X _____ Date _____
 (Signature of Policyholder if other than Premium Payor)



* 1 5 0 3 6 1 0 0 6 *

INSTRUCTIONS

- The insured's full name should be shown on page 1 and signed identically on page 4.
- **IF THE OWNER IS A TRUST OR BUSINESS PLEASE INCLUDE FULL TITLE AND NAME OF TRUST OR BUSINESS.**

Ex: Paula Smith, Trustee Paula Smith, President
Paula Smith Irrev Trust date 1-2-98 Paula's Shoe Store, Inc.

MAKE SURE THAT YOU HAVE THE COMPLETE NAME AND DATE OF TRUST AND IF IT IS REVOCABLE OR IRREVOCABLE.

- List all owners' tax IDs on page 1. If all owners' tax IDs are not included, we will require completed W-9 before issue.
- Proposed insureds age 15 and over are required to sign the application.
- When insuring the life of children under the age of 15 a parent's signature is required even if they are not the owner of the policy.
- For Independent Choices, Foundation Builder Plus, only the 5 YR Index and 5 YR Fixed-Term interest crediting strategies are available.
- Explain the terms of the Company's Conditional Life Insurance Agreement prior to accepting any settlement with the application.
- Leave the completed Conditional Life Insurance Agreement with the applicant if money is taken.
- Explain the Disclosure Notice and leave it with the Proposed Insured.
- Two applications need to be completed for joint life products—one for each insured.

When submitting an application you must include a) a fully completed illustration including both the applicant's and your signatures; or b), a completed certification stating that no illustration was presented at application; or c) an electronic illustration certification stating that an illustration was shown on a computer but that no hard copy was printed or presented to the applicant. Do not mark, highlight or write on the illustration.

If this application is completed for an indexed product in the states listed, you must provide a signed illustration with the application. A certification of non-illustration or electronic illustration only is not allowed: Arkansas, Connecticut, North Dakota, Oklahoma, South Dakota, Wyoming.

If the application is completed for an indexed product for the following states, the Applicant must initial or sign the Indexed Acknowledgments as indicated: Connecticut, Massachusetts, South Carolina, and Texas.

- Complete the Pre-Authorized Check Information if requesting billing mode of PAC.
- For faster service, fax the application to the number listed below. Please retain original, do not mail.

SPECIAL INSTRUCTIONS TO THE NEW BUSINESS STAFF:

TeleApp Application for Life Insurance

The Tele App program provides a simplified way to sell life insurance. You do the selling – we take care of all the rest, including all medical requirements.

Prepare your client(s) to expect a short telephone interview for medical questions. If required, the home office will have an examiner arrange a meeting with the client to complete a mini-exam and any other necessary requirements.

When the policy is approved the completed application will be sent to you along with the policy for the client's signature on delivery.

Make sure the following items are completed and signed (as needed):

- Financial Supplement Form for all amounts over \$1,000,000*
- Tele App Supplemental Questionnaire(s) for additional insureds and children as needed*
- PAC forms*
- Replacement forms*
- Signed illustration (or illustration certificate if allowed)*
- Other compliance forms in your state*

Send in the application(s) and we will take it from there.



Aviva Life and Annuity Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038





TeleApp Application for Life Insurance

AGENT CODE # _____

(In this application, "Company" refers to the insurance company named above.)

PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? Yes No
Address _____ Gender M F Maiden Name _____
City _____ State _____ Zip _____ Marital Status Married Single Divorced or Separated
U.S. Citizen? Yes No Permanent Resident? Yes No Widow or Widower
Birth Date _____ Birth State _____ Social Security Number _____
Home Ph. (____) _____ Bus. Ph. (____) _____ Employer _____
Annual earned income \$ _____ Annual unearned income \$ _____ Net worth \$ _____
Driver's License # _____ State _____ Issue Date _____ Expiry Date _____
Or, if you do not have a driver's license, other government issued photo ID: Document Type _____
Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____
Occupation _____ Duration of Employment _____

OWNER INFORMATION

OWNER (If different from Proposed Insured) Individual Business Trust (date of trust) _____
Name (Owner, Business or Trustee) _____ Address _____
Birth Date _____ City _____ State _____ Zip _____
If trust, name of trust _____
Relationship _____ Social Security # or Taxpayer ID # _____
Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:
Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

CONTINGENT OWNER

Driver's License # or other government issued photo ID document: Document Type _____ Document # _____
Where Issued _____ Issue Date _____ Expiry Date _____
Mail notices to Insured Owner Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type

- Qualified Plan: Type: Profit Sharing Plan 401(k) 412(i) Other Defined Benefit
Non-Qualified Plan: Type: Welfare Benefit Plan: single employer multiple employer VEBA Deferred Comp Split Dollar Executive Bonus Other Neither

BENEFICIARY INFORMATION

PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)

(If necessary, use an additional page for additional details, signature of owner & date.)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____
CONTINGENT BENEFICIARY(IES)

Print Full Name _____ Birth Date _____ Relationship _____ Percentage _____ Social Security # or Taxpayer ID # _____



POLICY INFORMATION

Plan Applied _____ Amt. of Ins. \$ _____ Nonsmoker/Nontobacco Smoker/Tobacco

UL Death Benefit Option: Level Increasing Death Benefit Return of Premium Rider

Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____

Additional Coverage _____ Amt. of Ins. \$ _____ Premium \$ _____

Riders _____

Waiver Type _____ Other Riders (Type/Amount) _____

RIDERS (complete supplemental application)

AIR \$ _____ Spouse Rider \$ _____ Child Rider \$ _____

PREMIUM INFORMATION

Premium Direction / Interest Crediting Strategy: 1 Year Point-to-Point _____% 2 Year Point-to-Point _____% 1 Year Monthly Average _____%
 1 Year Monthly Cap _____% 1 Year Average Multiple Index _____% 5 Year Fixed Term _____% 1 Year Fixed Term _____%

Levelized Strategy Transfer Yes No

Whole Life APL (if applicable) Yes No Direct Recognition (if available) Yes No

Premium Planned Premium \$ _____ Additional Premium (lump sum) \$ _____

Billing Frequency Annual Semi-Annual Quarterly PAC (Complete Authorization) Other _____

Govt. Allotment Group Bill Group Bill # _____

Has the premium for the policy applied for been given to the agent? Yes No Amount \$ _____

How Paid? Check Other (specify) _____

Policy Date (optional) _____ Other _____

Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy? Yes No
 (If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)

Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else? Yes No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

INSURANCE IN FORCE ON PROPOSED INSURED

Are any life insurance or annuity contracts in force? Yes No
 If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? Yes No

Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? ... Yes No

Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? Yes No

Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? Yes No

Has the proposed insured ever had or been treated by a medical professional for diabetes, heart disease, cancer, alcoholism or drug abuse?
 Yes No

Give complete details of any **Yes** answers to the questions in this section. (If necessary, use an additional page for additional details,

signed by the applicant and dated.) _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.



TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner**.

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to the payor; OR
- (2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
- (4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required shall be treated as representations and not as warranties. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**



AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, 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, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company 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 responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 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 at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

On _____
Date

X _____
Signature of Owner if other than Proposed Insured

X _____
Signature of Licensed Agent

Parent/Guardian or Witness (if required)

If Owner is a corporation, business firm or trust, give full name and
an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:





1. Please list all existing policies/contracts with an Aviva company that have this Trust as owner or beneficiary:

2. Full Name of Trust: _____
Please be sure to accurately state the Trust's full name.

3. Date of Trust: _____ 4. State Law that Governs the Trust: _____

5. TRUST TAX IDENTIFICATION NUMBER (Please check one):

The Trust does not have a separate taxpayer identification number and the personal taxpayer identification number of the FIRST Settlor/Grantor listed below should be used; or

The Trust tax identification number is _____

6. First/Last Name of Settlor/Grantor of Trust _____ Social Security Number _____

1. _____

2. _____

(Please attach additional pages if insufficient space has been provided.)

7. Names of ALL current Trustees:

1. _____

2. _____

3. _____

(Please attach additional pages if insufficient space has been provided.)

Note: Company policy and the rules of most state insurance departments prohibit an agent from acting as the Trustee of a client's Trust, unless that agent is a family member.

8. Names of ALL successor Trustees (if applicable):

1. _____

2. _____

3. _____

(Please attach additional pages if insufficient space has been provided.)

9. The Trust Agreement requires that; (Please mark the appropriate box)

ANY of the current Trustees, acting alone All of the Trustees acting together Other (explain)
must sign or otherwise authenticate forms and/or requests on behalf of the Trust in connection with insurance products.

10. Neither the insurance agent or any person affiliated with the insurance agent is a beneficiary of the Trust.

Agree Disagree

If you marked Disagree, please attach an explanation of why they are named a beneficiary of the Trust

Note: Under the laws of most states, an agent is restricted in, or prohibited from, having a beneficial interest in a contract/policy sold by that agent, unless that agent is a family member, or has a recognized insurable interest.

11. The Trust is validly executed and in full force and effect? Yes No

Note: Trust must be formed and domiciled in the United States or one of its Territories at all times.

12. Names of Notary and/or Witnesses of Trust:



* 1 6 5 4 1 0 9 0 8 0 1 *

Certifications by Trustee(s)

The Trustee(s) states and agrees that:

The Trust, if named owner, is authorized under the terms of the Trust to purchase and/or hold insurance on the life of any insured/annuitant. If named beneficiary, the Trust is authorized to receive proceeds as provided under the terms of the insurance policy and/or annuity contract. I/we have also determined the insurance product is appropriate for the Trust's purpose and the terms of the insurance product conforms to the income distribution requirements, if any, of the Trust.

I/We certify that the Company may rely solely on this Verification and the information provided for policy/contract administration purposes and the Company has no obligation to investigate the terms of the Trust or the authority of the Trustee(s). The Company expressly denies responsibility regarding the use and applications of any payments made to the Trust by the Trustee(s) and the Trustee(s) will hold the Company harmless from any action the Company takes at the direction of the Trustee(s).

The Trustee(s) declares that each and every Trustee and successor Trustee are bound by this certification. It is further understood that the Company may rely upon the direction of the named Trustee(s) until the Company receives written notification at its Home Office of a change of Trustee. Furthermore, the Trustee(s) agrees to notify the Company of any changes to the Trust itself that will alter the information provided in this Trust Verification.

The signature(s) below certify the previous information provided and agreed to on this Verification is true and accurate:

Note: The number of Trustees indicated in Question 7 must sign below

Signature of Trustee	Date
Signature of Trustee	Date
Signature of Trustee	Date

Please be advised that the Company reserves the right to request and receive a copy of the Trust documents if it is determined that it is necessary to do so. Prior to payment of death benefit proceeds, the Company may also require proof that the Trust is then in full force and effect.





Supplemental Questionnaire for the TeleApp

(In this questionnaire, "Company" refers to the insurance company named above.)

1. Name of Primary Insured (First, middle, last) _____
Policy # (if known) _____

2. Additional Insured Rider _____ Amount _____ Tobacco Non-tobacco
 Spouse Rider _____ Amount _____ Tobacco Non-tobacco
 Children's Insurance Rider _____ Amount _____

3. **Proposed insured(s)**

Name (First, Middle, Last) _____ Gender M F

Birth Date _____ Age _____ Height _____ Weight _____ Birth State _____ S. S.# _____ Occupation _____

Amount of life insurance in force including ADB _____ Relationship to Proposed Insured _____

Name (First, Middle, Last) _____ Gender M F

Birth Date _____ Age _____ Height _____ Weight _____ Birth State _____ S. S.# _____ Occupation _____

Amount of life insurance in force including ADB _____ Relationship to Proposed Insured _____

Name (First, Middle, Last) _____ Gender M F

Birth Date _____ Age _____ Height _____ Weight _____ Birth State _____ S. S.# _____ Occupation _____

Amount of life insurance in force including ADB _____ Relationship to Proposed Insured _____

If there are additional children to be covered check here and complete a second Supplemental Questionnaire.

4. Address of Additional Insured _____ Phone # _____

5. Will any annuity or life insurance presently or recently in force be replaced or changed by any new coverage if issued? Yes No
(if yes, enclose replacement form(s))

6. Has any proposed insured ever had or been treated by a medical professional for diabetes, heart disease, cancer, alcoholism or drug abuse? Yes No

Please provide details _____

7. Has any proposed insured ever been declined, rated, had coverage modified or withdrawn, or reinstatement declined by any insurance company? Yes No

8. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? Yes No

9. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? Yes No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.



AUTHORIZATION AND ACKNOWLEDGEMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

It is hereby represented that the answers and statements on the application(s) and any Supplements required shall be treated as representations and not as warranties. I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, 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, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company 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 responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 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 at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I recognize that by signing this questionnaire I will be contacted by phone to complete a life insurance application.

Date

X _____
Signature of Proposed Insured and/or Parent/Guardian

X _____
Signature of Licensed Agent

X _____
Signature of Owner

