



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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Signed at \_\_\_\_\_  
City State Date Signature of Agent

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**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

## Notice and Consent for AIDS-Related Testing

The decision to have an HIV test is voluntary. To evaluate your insurability, the insurer named above (the Insurer) may request that you provide a sample of your blood or other body fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

### Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

### Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS Information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

### Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician below so that the Company can have him or her tell you the test result and explain its meaning. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

### Consent

I have read and I understand this Notice and Consent AIDS-Related Testing. I voluntarily consent to provide a sample of blood or other body fluid, the testing of that blood or other body fluid, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name and address of physician for reporting a possible positive test result:

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Signature of Proposed Insured or Parent/Guardian

Date Signed: \_\_\_\_\_

**Washington State Department of Health  
HIV/AIDS Prevention & Education Services  
HIV TESTING AT LOCAL HEALTH JURISDICTIONS**

Testing availability may vary from county to county. Some local health departments/districts only provide referrals to testing. There may also be other agencies within the county that perform HIV testing.

Adams County Health Department  
103 W Main, Ritzville 99169-1407  
(509) 659-3319

Asotin County Health Department  
431 Elm, Clarkston 99403  
(509) 758-3344

Benton-Franklin Health District  
506 McKenzie, Richland 99352-3520  
(509) 943-2614 - Richland  
(509) 547-9737 - Pasco  
(509) 586-0207 - Kennewick

Bremerton-Kitsap Health District  
109 Austin Drive, Bremerton 98312  
(360) 478-5235/800-874-2437

Chelan-Douglas Health District  
PO Box 429, Wenatchee 98807-0429  
(509) 664-5306/800-336-5306

Clallam County Health Department  
223 E 4th, Pt Angeles 98362-3098  
(360) 417-2352

Columbia County Health District  
221 E Washington, #101 PH, Dayton 99328  
(509) 382-2181

Cowlitz County Health District  
600 Broadway, Longview 98632-7269  
(360) 414-5599

Garfield County Health District  
PO Box 130, Pomeroy 99347  
(509) 843-3412

Grant County Health District  
1021 W Broadway, Moses Lake 98837  
(509) 766-7960

Grays Harbor County Health Department  
2109 Sumner Ave, Aberdeen 98520  
(360) 532-8631

Island County Health Department  
PO Box 5000, Coupeville 98239-5000  
(360) 679-7351

Jefferson County Health Department  
Castle Hill Center, 615 Sheridan,  
Pt Townsend 98368-2439  
(360) 385-9400

King County - Seattle  
AIDS Prevention Unit (206) 205-7837  
800-678-1595  
Harborview Hospital STD Clinic  
- no anonymous HIV testing (206) 731-3590  
Harborview Women's Clinic (206) 223-3367  
Seattle Gay Clinic (206) 461-4540

Kittitas County Health Department  
507 Nanum, Ellensburg 98926  
(509) 962-7515

Klickitat County Health Department  
(509) 493-1558 White Salmon  
(509) 773-4565 Goldendale

Lewis County Health Department  
360 NW North, Chehalis 98532-1900  
(360) 740-1223/800-562-6130

Lincoln County Health Department  
PO Box 1207, Davenport 99122  
(509) 725-1001

Mason County Health Department  
303 N 4th, Shelton 98584  
(360) 427-9670 x 400

Northeast Tri-County Health District  
PO Box 270, Colville 99114  
(509) 684-5048

Okanogon County Health District  
PO Box 231, Okanogon 98840  
(509) 422-7140

Pacific County Health Department  
PO Box 26, South Bend 98586  
(360) 875-9343

Pierce County Health Department  
3629 S D St, Tacoma 98408-6897  
(253) 798-6060

San Juan County Health Department  
PO Box 607, Friday Harbor 98250-0607  
(360) 378-4474

Skagit County Health Department  
700 S 2nd, Rm 301, Mt Vernon 98273-3684  
(360)336-9380

Skamania County Health Center  
683 SW Rock Creek Dr, Stevenson 98648  
(509) 427-5138

Snohomish Health District  
3020 Rucker Ave #206, Everett 98201-3971  
(425) 339-5251/800-344-2437

Southwest Washington Health District  
2000 Ft Vancouver Way, Vancouver 98663  
(360) 696-8425

Spokane County Health District  
1101 W College Ave, Spokane 99201-2095  
(509)324-1600/800-456-3236

Thurston County Health Department  
529 SW 4th Ave, Olympia 98501-1097  
(360) 786-5581 x 6944

Walla Walla County Health Department  
PO Box 1753, Walla Walla 99362-0346  
(509) 527-3290

Wahkiakum County Health Department  
PO Box 397, Cathlamet 98612  
(360) 795-6207

Whatcom County Health Department  
1500 N State St, Bellingham 98225  
(360) 676-4593

Whitman County Health Department  
N 310 Main, Colfax 99111  
(509) 397-6280

Yakima Health District  
104 N First, Yakima 98901-2267  
(509) 249-6518/800-535-2271



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, 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

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.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.



## 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 are complete, true and correctly recorded. 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

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.



**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**

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





**Aviva Life and Annuity Company**  
 611 Fifth Ave.  
 Des Moines, IA 50309-1603

## IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

### STATEMENT TO APPLICANT BY AGENT OR BROKER

(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain: \_\_\_\_\_
2. Are there penalties, set up or surrender charges for the new policy?  No  Yes, explain, emphasizing any extra cost for early withdrawal: \_\_\_\_\_
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  No  Yes, explain: \_\_\_\_\_
4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain: \_\_\_\_\_
5. a) Are interest earnings a consideration in this replacement?  No  Yes  
 b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain: \_\_\_\_\_
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
  - a) Are the interest rates quoted before  or after  fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_ c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_ and the limit on the amount that can be borrowed is \_\_\_\_\_
  - e) The surrender charges are: \_\_\_\_\_
  - f) The death benefit is \_\_\_\_\_
8. Are there other short or long term effects from the replacement that might be materially adverse?  No  Yes, explain: \_\_\_\_\_

Signature of Agent or Broker	Date
Name of Agent or Broker (Print or Type)	Address
List of Policies or Contracts to be Replaced:	

Company	Insured	Contract No.
---------	---------	--------------

**CAUTION:** The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_

After we have issued your policy, you will have twenty days from the date the new policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.**

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number

RETURN TO AVIVA, PROVIDE COPY TO APPLICANT, KEEP COPY FOR YOUR RECORDS

