

Life Investors Ultima Products Application Cover Sheet

Attention: New Business

Fax # 800-535-1325

Please send an application cover sheet with each application.

(Applications can be scanned and e-mailed to us by using the e-mail documents link on agentnetinfo.com.)

Date: _____ Number of pages: _____
(Including cover sheet)

Agent Name: _____ Agent Number: _____

Agent Phone #: _____ Agent Fax #: _____

Proposed Insured Information:

Name: _____

Home Phone Number: _____

Work Phone Number: _____ (Only complete if you wish to be contacted at work.)

Best time of day / evening to call: _____

Are there any special language needs? _____

Other comments/special instructions:

APPLICATION COMPLETION TIPS

- **Submit a complete and accurate application with necessary supplemental forms.**
- Please **retain your original copy of this fax.** We reserve the right to request the original if we are unable to read the fax.
- Use permanent **black ink. LEGIBLY PRINT** in English.
- **NO** white out. Any changes to written answers must be initialed by applicant/proposed insured.
- **MEDICAL INFORMATION** – Full details must be provided. If additional space is required, please provide on a separate piece of paper signed by Insured/Owner.
- Submit a **copy of check** with application. However, we will require the **original cash or check** in order to place a case and pay commissions.
- Mail **original 1035 form** (if applicable) within **5 working days** of the fax.
- Arrange for necessary **MEDICAL REQUIREMENTS.** Indicate on Agent's report **all requirements ordered.**
- Illustration or Illustration Certification required in **NAIC States** for Universal Life.
- If you wish to mail the **original application**, please indicate that you have previously faxed the application.

APPLICATION FOR INSURANCE

[Standard]

Life Investors Insurance Company of America
Home Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499

PROPOSED INSURED INFORMATION

Name (First, M.I., Last)				Mailing Address			
Home Telephone No. ()		Work Telephone No. ()		Birth Date	Birth Place (State or Country)		E-Mail Address
Height	Weight	Marital Status		Sex	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, give immigration status/type of visa:
Occupation & Duties			Annual Income Current Year _____			Social Security No. or Tax I.D. No.	
			Annual Income Previous Year _____			Drivers License No./ State	
Net Worth _____							
Have you used any tobacco within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and when used last _____							

BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED (Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)

Primary	Contingent
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OWNER(S) (Unless otherwise noted, the Owner will be the Insured. For Florida applicants, you may name a secondary addressee to receive notice of possible lapse in coverage - complete the Additional information section.)

Name	Relationship to Proposed Insured	Social Security Number
Address	Birth Date	Phone ()

POLICY INFORMATION

Plan: _____	Amount of Insurance	Planned Premium
<input type="checkbox"/> Level <input type="checkbox"/> Increasing Guarantee Period _____	\$	\$

DISABILITY INCOME

PLAN _____	AMOUNT: BASE _____	SIR _____
BENEFIT PERIOD _____	ELIM. PER _____	OCCUPATIONAL CLASS _____
OPTIONAL RIDERS (SPECIFY RIDER, AMOUNT, ETC.) _____		
TOTAL INITIAL DISABILITY INC. PREM. \$		

Mode of Payment (for bank draft, complete Check-O-Matic authorization, and initial payment required.)
 Monthly Bank Draft Quarterly Semi-Annual Annual

BENEFIT/RIDERS

	Benefit Units Monthly \$ Amount		Benefit Units Monthly \$ Amount
<input type="checkbox"/> Waiver of Premium Benefit (WP)	_____	<input type="checkbox"/> Income Replacement Rider (IRBR)	_____
<input type="checkbox"/> Waiver of Monthly Deduction	_____	Level Term Period (Years) <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 25 <input type="checkbox"/> 30	_____
<input type="checkbox"/> Children's Rider	_____	<input type="checkbox"/> Return of Premium Rider	_____
<input type="checkbox"/> Additional Insured Rider (AIR)	_____	<input type="checkbox"/> Unemployment Benefit Rider	_____
<input type="checkbox"/> Base Insured Rider (BIR)	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Accidental Death Benefit (ADB)	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Guaranteed Insurability Rider (GIR)	_____	<input type="checkbox"/> Other _____	_____

Name of Other Proposed Insured(s)	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco in last 5 years? If yes, list type and when used last
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

LIFE INSURANCE IN FORCE		
Insured's Name	Company/ Policy Number	Face Amount
		\$
		\$
		\$
		\$

DISABILITY INCOME - INSURANCE IN FORCE <i>(Complete only if Disability Coverage is being applied for)</i>				
Insured's Name	Company/ Policy Number	Monthly Amount	Benefit Period	Elimination Period

PERSONAL PHYSICIAN(S)		
Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

GENERAL QUESTIONS Complete the following. *For YES answers, give full details in the space provided on the next page.*

- Will the insurance applied for replace or change any existing insurance or annuity? Yes No
- Have you or any proposed insured,**
- Had any health, disability or life insurance pending or contemplated with another company? Yes No
- Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? Yes No
- Within the past 5 years,
 - Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? Yes No
(If yes, provide state and drivers license number.)
 - Been or is now fully or partially disabled? Yes No
 - Been charged with or convicted of any felony or been on probation? Yes No
- Within the past 2 years,
 - Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? Yes No
 - Flown other than a passenger, or plan to? (If yes, complete the Aviation Supplement.) Yes No
 - Foreign residence or travel contemplated? Yes No
- Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? Yes No
- Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60? Yes No
- Do you exercise? If yes, describe type, how often per week and how long per session. Yes No
- Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. Yes No
- Have you had any weight change in the past year? Yes No

MEDICAL QUESTIONS Each question must be individually asked and answered. *For YES answers, give full details in the space provided on the next page.*

Within the past 10 years, has any proposed insured been treated or diagnosed by a health care professional as having any disease or disorder of the:

- Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? Yes No
- Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? Yes No
- Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? Yes No
- Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? Yes No
- Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? Yes No
- Endocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? Yes No
- Cancer, tumor, polyps, melanoma or other malignancy? Yes No
- Had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? Yes No
- Are you currently under the observation of a physician or taking medication? Yes No

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

For applicants in **ARKANSAS, LOUISIANA**

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 is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in **COLORADO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For applicants in **FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

For applicants in **KENTUCKY, OHIO, and PENNSYLVANIA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in **MAINE, VIRGINIA, TENNESSEE and DISTRICT OF COLUMBIA**

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 and denial of insurance benefits.

For applicants in **MINNESOTA**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For applicants in **NEW JERSEY**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in **NEW MEXICO**

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 is guilty of a crime and may be subject to fines and criminal penalties.

Under penalties of perjury, I hereby certify (1) that the Social Security or Taxpayer I.D. number above on this application is correct and (2) that I am currently not subject to backup withholding. [Cross out (2) if not correct.] See below***

The statements and answers on this Application are true and complete to the best of my knowledge and belief. It is agreed that (a) this application and any amendments hereto, shall be the basis of any insurance granted; (b) no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the other Company's rights or requirements or to make or alter any contract; (c) acceptance of any policy issued shall constitute ratification of any endorsements in the space entitled "For Administrative Office Endorsement," except that no change in the amount, classification, plan of insurance or annuity, or benefits shall be effective unless agreed to in writing by the Applicant, and (d) no insurance or annuity shall be considered in force unless and until a policy shall have been issued by the Company and said policy manually received and accepted by the Applicant and the full first premium paid thereon, all during the lifetime and before any change in the insurability of any person proposed for insurance from that stated herein.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

Unless otherwise stated the undersigned Applicant is the Premium Payor and the Owner of the policy applied for.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, Medical Information Bureau, the Veteran's Administration, or other health care provider, my employer and any consumer reporting agency or insurance company who possess information concerning any care, treatment or advice rendered to me to provide such information to Life Investors Insurance Company of America, its representatives or its reinsurers. A photocopy of this Authorization shall be considered as valid as the original, which I or my authorized representative may receive a copy of upon request. Life Investors Insurance Company of America, or its reinsurers, may release this information about me to its reinsurers, to the Medical Information Bureau or to another insurance company to which I have applied. This authorization is limited to a period of 30 months commencing on the date of this application. I represent that the foregoing statements are complete and true to the best of my knowledge and belief. I understand that the date coverage becomes effective for any policy applied for on this application will be the date recorded on the Policy Specification page, not the date the application is signed. I understand coverage will be effective when the first premium is paid, provided all persons proposed for insurance are acceptable to the company under its rules and limits as standard risks, on the plan and for the amount applied for and the rate of premium declared. I authorize payroll deduction of the premiums, and acknowledge receipt of the MIB Disclosure Notice and Fair Credit Reporting Act Notice.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Dated at _____ city _____ state this _____ day of _____ month _____, _____ year

Signature of Proposed Insured

Signature of Additional Insured

Signature of Applicant if Other Than Insured

Owner Other

Signature of Parent or Legal Guardian for Insured's 15 and under

Best time to call for a personal history interview _____ a.m. _____ p.m. Okay to contact at work? Yes No

AGENT INFORMATION & SIGNATURE

_____ Signature of Agent	_____ (Print Last Name)	_____ Agent #
(_____)_____ Telephone Number	(_____)_____ Fax Number	_____ E-mail address
_____ Split Agent Signature (If Applicable)	_____ (Print Last Name)	_____ Agent #
(_____)_____ Telephone Number	(_____)_____ Fax Number	_____ E-mail address
Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, what company? _____		Policy # _____
SUBMIT SPECIAL REPLACEMENT FORM IF REQUIRED IN YOUR STATE		

ILLUSTRATION CERTIFICATION

I certify that no illustration was used by me or any other authorized agent of Life Investors Insurance Company of America in the sale of the life insurance to _____
 _____ APPLICANT
 on this date. An illustration conforming to the requirements of the _____ state regulation
 _____ STATE
 on illustrations will be delivered to this applicant no later than the policy delivery date.

 DATE AGENT

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

 DATE APPLICANT

AGENT'S REPORT

How well do you know proposed insured? _____
 Yes No

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance?
 (If "yes", explain in Remarks Section) Yes No

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)
 (If "yes", explain in Remarks Section) Yes No

Did you see all of those to be insured on the date the application was written?
 (If "no", explain in Remarks Section) Yes No

Is insurance being applied for with any other company?
 (If "yes", give details in Remarks Section) Yes No

Did you witness the signing of the application?
 (If "no", explain in Remarks Section) Yes No

Did you ask each question in this application exactly as printed?
 (If "no", explain in Remarks Section) Yes No

If application is approved other than as requested:
 Adjust to premium

Issue face amount as shown

Is applicant being examined by a medical doctor? Yes No

Is an EKG being arranged? Yes No

Is an exercise EKG being arranged? Yes No

Is a blood profile being arranged? Yes No

COMPLETE ONLY IF OWNER IS OTHER THAN INSURED

OWNER IS: Corporation Partnership
 Individual Sole Proprietorship Trust

Purpose of Policy
 Personal Needs Analysis Estate Liquidity
 Mortgage Buy-Sell
 Retirement Key Employee
 Education Other

If application is for key-man insurance, on what basis was the applicant's value to the business determined?

Who will pay the premium? _____

Total of other insurance on proposed insured payable to business. _____
 If partnership, give names of all partners. _____

Are all other partners insured? If not, explain. _____

Relationship of owner to Insured? _____

How much life insurance is carried by
 (a) Father _____ b) Mother _____
 (c) If this application is greater than a or b above
 (Explain in Remarks Section)

If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives
 (in Remarks Section)

1. Agent's Name	Account No.	% if Split
2. Agent's Name	Account No.	% if Split

Rate Class:
Universal Non-Tobacco Tobacco
 Preferred Preferred Plus
 Preferred Plus Non-Tobacco
 Preferred Tobacco Preferred Tobacco
 Tobacco
Term
 Preferred Elite
 Preferred Plus
 Preferred
 Non-Tobacco
 Preferred Tobacco
 Tobacco
 Other _____

ADDITIONAL REMARKS/AND OR SPECIAL INSTRUCTIONS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy, if the health of the insured has changed.

 Signature of Writing Agent
 Print name and account number of, and percentages for agent or agents who are to receive credit and commission.

PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN

Authorization to Insurance Company

The Premium Payor hereby authorizes Life Investors Insurance Company of America to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Home Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided on the reverse side. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing on the reverse side.

Please attach a voided check or deposit slip.

Bank Name and Address (Name, Office or Branch, Street Address, City, State, Zip Code)		
Policy Number	Check-O-Matic Premium	Date of First Withdrawal

Authorization to Financial Institution

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other order's whether by electronic or paper means, with such debits made to my account and drawn or directed by Life Investors Insurance Company of America to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Transit Routing Number	Account Number
Payor Name(s)	Payor Signature(s) <i>Your signature as on financial institution's records. A copy is as valid as the original</i>

----- **Detach and leave with applicant if cash is paid with application** -----

LIFE INSURANCE CONDITIONAL RECEIPT, Life Investors Insurance Company of America

Please read this carefully. All premium checks must be made payable to Life Investors Insurance Company of America. Do not make check payable to agent or leave payee blank.

Received from _____ the sum _____ paid with a life insurance application to the Company. The application bears the same date as this receipt. There will be no coverage if the sum received is paid by a check which is uncollectible upon initial deposit. The full initial premium payment for the mode of payment chosen is required for this conditional receipt to be effective.

The person(s) proposed to be insured is (are) _____

No agent or broker is authorized to alter the terms of this Receipt, waive any requirements, or pass on insurability.

Dated at (City and State)	On (Date)	Agent's Signature
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The life insurance contract you have applied for with the Company will not become effective unless and until a contract is delivered to you. Subject to the conditions and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy applied for will become effective prior delivery. No insurance will be provided under this Receipt unless and until all the following requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- **As of the effective date herein defined, each person proposed to be insured is found to be insurable exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;**
- **The payment taken for this Receipt is not less than the full initial premium for the mode of payment chosen in the application;**
- **All medical examinations, tests, and other screenings required by the Company are completed and received at our Home Office within 60 days from the date of the completion of the application; and**
- **As of the effective date, the state of health and all factors affecting the insurability of each person proposed to be insured are stated in the application.**

----- **Detach and leave with applicant** -----

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION to Proposed Insured And Other Proposed to be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report. Ordinarily, it will be provided to third parties only if you authorize us in writing to do so. In rare instances, we may be required to prove some or all of the information without your consent.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs, sport, hobby or aviation activities, and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know. If you feel any information in our file is incorrect or incomplete, you may ask us to review it. If we agree, we will make any necessary corrections and inform anyone who received such information within the past two years. If we do not agree, you may file a statement of dispute with us. We will send that statement to anyone receiving such information in the past two years. We will also include it in any future disclosure of the disputed information.

The Financial Institution Named on the Reverse Side

In consideration of your compliance with the request and authorization on the reverse side of this form, and of your participation in the Check-O-Matic Premium Payment Plan with Life Investors Insurance Company of America, incorporated under the laws of the State of Iowa, (hereinafter called the Company), it is hereby agreed that:

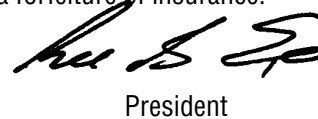
The Company will indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any debit by check, draft, or other order, whether by electronic or paper means, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any cost or expenses reasonably incurred in connection therewith.

The Company will refund to you any amount you have paid to it in error upon receipt of a claim which you may submit at any time up to twelve months after the date of such payment.

The Company will defend, at its expense, any action which might be brought by any depositor, beneficiary, or assignee or any other person because of your actions taken pursuant to the depositor's or the Company's request or in any manner arising by reason of your participation in the Company's Check-O-Matic Premium Payment Plan.

In the event that any such debit shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, the Company will indemnify you for any loss even though dishonor results in a forfeiture of insurance.


Secretary


President

Conditions Applicable to Check-O-Matic Premium Payment Plan

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll Free 1-800-625-4213

Or Write: Life Investors Insurance Company of America, 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

Detach and leave with applicant

LIFE INSURANCE CONDITIONAL RECEIPT (CONTINUED)

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company shall be limited to a refund to the applicant of the payment made for this receipt.

This receipt will provide insurance starting at the effective date. The effective date is the latest date of the following events:

- Signing of all parts of the application, any supplemental application or addendum to application, or any medical examination.
- Date requested in the application that is acceptable to the Company.
- The last required test(s) and medical examination(s) are performed.
- The full initial premium for the mode of payment chosen is received at our Home Office.
- Any additional information required by us is received at our Home Office.

This Receipt will terminate on the earliest of: (a) 60 days from the date this Receipt was signed; (b) the date the Company mails notice to the applicant of the rejection of the application for insurance and refunds the premium paid; (c) the day before the date insurance goes into effect under the policy applied for; or (d) the date the Company offers insurance other than as applied for.

The aggregate amount of life insurance on each person proposed to be insured which may become effective under this Receipt and any other conditional Receipt issued by the Company will be the lesser of the amount applied for or \$500,000 of the life insurance. This Receipt provides no insurance for riders or additional benefits.

If one or more of this Receipt's conditions have not been met exactly, the Company will be free from any liability except to return the premium payment.

The Company does not approve and accept the application for insurance within 60 days from the date this Receipt was signed, the application will be deemed to have been rejected by the Company and the Company shall have no liability except to return any payment made for this Receipt on surrender of this Receipt to the Company.

Detach and leave with applicant if cash

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION to Proposed Insured And Other Persons Proposed to be Insured, If Any information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105; Essex Station; Boston, Massachusetts 02122; telephone number (617) 426-3660.

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage to which a claim may be submitted.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children (except psychotherapy notes) and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, those containing diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs, and tobacco.
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

Parent Legal guardian Power of Attorney Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

- Life Investors Insurance Company of America
- Monumental Life Insurance Company
- Stonebridge Life Insurance Company
- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

**Notice and Consent for
HIV-Related Testing
WASHINGTON**

To evaluate your insurability, the Insurer designated above (“the Insurer”) has requested that you provide a sample of your bodily fluid(s) 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 tests will be performed by a certified laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-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.

The Department of Health and Human Services Office on HIV/AIDS has prepared the attached listing of medical facilities which provide HIV pre-test counseling. Behaviors that place you at risk for HIV infection include sexual contact or sharing needles or syringes with an infected person.

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.

Positive HIV antibody/antigen test results do not mean that you have AIDS but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A positive HIV antibody test result will probably mean you will be declined for the insurance for which you are applying.

A negative result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. 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. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive or indeterminate, Washington state law [WAC 248-100-209 (4)] requires that post-test counseling occur at the time the test result is given to you. Please designate your private physician in the space provided below so that the insurer can have him or her tell you the test result and provide the required post-test counseling. If you do not designate a physician, the insurer will disclose the test result to the local health department so they may give the test result to you and provide the required post-test counseling. According to Washington state law positive or indeterminate test results cannot be sent directly to you.

Name of physician for reporting a positive or indeterminate test result:

_____ Health Care Provider

_____ Street

_____ Phone Number

_____ City, State, Zip Code

**Notice and Consent for
HIV-Related Testing
WASHINGTON**

Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing* which may include AIDS Virus (HIV) Antibody/Antigen testing. I voluntarily consent to providing a sample of my bodily fluid(s), the testing of my bodily fluid(s) and the disclosure of the test results as described above.

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 of Proposed Insured (*Please Print*)

Signature of Proposed Insured

Street

Date Signed

City, State, Zip Code

Date of Birth

HIV Antibody Testing/Counseling Services

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by Washington law, the following list of counseling resources is being provided to you. It was provided by the Department of Health and Human Services Office on HIV/AIDS, which is subject to change without notice.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department or your local chapter of the American Red Cross for further information.

Adams County Health Department

103 West Main
Ritzville, Washington 99169-1407
(509) 659-3319

Asotin County Health District

431 Elm Street
Clarkston, Washington 99403
(509) 758-3344

Benton-Franklin Health District

506 McKenzie
Richland, Washington 99352-3520
(509) 943-2614 (Richland)
(509) 546-9737 (Pasco)
(509) 586-0207 (Kennewick)

Bremerton-Kitsap County Health Department

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

Chelan-Douglas County Health District

P.O. Box 429
Wenatchee, Washington 98807-0429
(509) 664-5306 / (800) 336-5306

Clallam County Health Department

223 East Fourth Street
Port Angeles, Washington 98362-3098
(360) 417-2352

Columbia County Health District

221 E. Washington Street, Suite 101 PH
Dayton, Washington 99328
(509) 382-2181

Cowlitz-Wahkiakum Health District

600 Broadway
Longview, Washington 98632-7269
(360) 414-5599

Garfield County Health District

10th & Columbia (P.O. Box 130)
Pomeroy, Washington 99347
(509) 843-3412

Grant County Health District

1021 Broadway
Moses Lake, Washington 98837
(509) 776-7960

Grays Harbor County Health Department

2109 Sumner Avenue
Aberdeen, Washington 98520
(360) 532-8631

Island County Health Department

P.O. Box 5000
Coupeville, Washington 98239
(206) 679-7351

Jefferson County Health Department

Castle Hill Center
615 Sheridan
Port Townsend, Washington 98369-2439
(360) 385-9400

Kittitas County Health Department

507 Nanum
Ellensburg, Washington 98926
(509) 962-7515
(509) 773-4565 Goldendale
(509) 493-1558 White Salmon

Lewis County Health District

360 N.W. North Street
Chehalis, Washington 98532-1900
(360) 740-1223 / (800) 562-6130

Lincoln County Health Department

P.O. Box 1207
Davenport, Washington 99122
(509) 725-1001

Mason County Health Department

303 North 4th
Shelton, Washington 98584
(360) 427-9670, Ext. 400

Northeast Tri-County Health District

P.O. Box 270
Colville, Washington 99114
(509) 684-5048

Okanogan County Health District

P.O. Box 231
Okanogan, Washington 98840
(509) 422-3867

Pacific County Health Department

P.O. Box 26
South Bend, Washington 98586
(360) 875-9343

Pierce County Health Department

3629 S D Street
Tacoma, Washington 98408-6897
(253) 798-6060

San Juan County Health Department

P.O. Box 607
Friday Harbor, Washington 98250-0607
(360) 378-4474

King County - Seattle**AIDS Prevention Unit**

(206) 205-7837 / (800) 678-1595

Harborview Hospital STD Clinic

No anonymous testing
(206) 731-3590

Harborview Women's Clinic

(206) 223-3367

Seattle Gay Clinic

(206) 461-4540

Skagit County Health Department

700 South Second Street, Room 301
Mount Vernon, Washington 98273-3684
(360) 336-9380

Skamania County Health Department

683 SW Rock Creek Drive
Stevenson, Washington 98648
(509) 427-5138

Snohomish Health District

3020 Rucker Avenue, Suite #206
Everett, Washington 98201-3971
(206) 339-5251 or 1-800-344-2437

Southwest Washington Health District

2000 Fort Vancouver Way
Vancouver, Washington 98663
(360) 696-8425

Spokane County Health District

West 1101 College Avenue
Spokane, Washington 99201-2095
(509) 324-1600 / (800) 456-3236

Thurston County Health Department

529 Southwest Fourth Avenue
Olympia, Washington 98501-1097
(206) 786-5581 Ext. 6944

Wahkiakum County Health Department

P. O. Box 397
Cathlamet, Washington 98612
(360) 795-6207

Walla Walla County-City Health Department

310 West Poplar (P.O. Box 1753)
Walla Walla, Washington 99362
(509) 527-3290

Whatcom County Health Department

1500 N. State Street
Bellingham, Washington 98225
(206) 676-4593

Whitman County Health Department

North 310 Main Street
Colfax, Washington 99111
(509) 397-6280

Yakima County Health District

104 North First Street
Yakima, Washington 98901
(509) 249-6518 / (800) 535-2271

LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

1. Find a policy that meets your needs and fits your budget
2. Decide how much insurance you need
3. Make informed decisions when you buy a policy

Prepared by the National Association of
Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need— and for how long— and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or timely death. Life

insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

1. If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
2. It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
3. Ask your tax advisor if dropping your policy could affect your income taxes.
4. If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
5. You may have valuable rights and benefits in the policy you now have that are not in the new one.
6. If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
7. At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or

company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

1. How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
2. Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
3. How will my family pay final expenses and repay debts after my death?
4. Do I have family members or organizations to whom I would like to leave money?
5. Will there be estate taxes to pay after my death?
6. How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period — even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY.

You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agency or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustrations are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

1. Do premiums or benefits vary from year to year?
2. How much do the benefits build up in the policy?

3. What part of the premiums or benefits is not guaranteed?

4. What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up your policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies—those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

1. How quickly does the cash value grow? Some policies have low cash values in the early years that build up quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)

2. Are there special policy features that particularly suit your needs?

3. How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Life Investors Insurance Company of America

Peoples Benefit Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy within 24 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose. In the event that our Physician provides a different diagnosis of the Insured's medical condition, you have the right to arbitration conducted in accordance with Washington Statutes chapter 7.04.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

If you receive payment of accelerated death benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Receipt of accelerated death benefits may be taxable and you should consult your personal tax advisor.

The accelerated life insurance benefit is intended to qualify under section 101(g) (26 U.S.C.101(g)) of the Internal Revenue Code of 1986 as amended by Public Law 104-191.

The table below is for illustration purposes only and is not a contract. These values will change based on the actual percentage of accelerated benefit elected, the applicable discount rate at the time the Single Sum Benefit is paid, any processing charge if applicable and when the claims process is completed.

Policy Values and Benefits

Prior to Payment of Benefit				After Payment of Benefit			
Pol Year	Specified Amt	Death Benefit	Cash Sur Value	Single Sum Benefit	Specified Amt	Death Benefit	Cash Sur Value
1	\$70,000.00	\$70,000.00	\$0.00	\$30,343.07	\$35,000.00	\$35,000.00	\$0.00

This table assumes a Single Sum Benefit of 50% is elected and the discount rate used to determine this Benefit is 7.40%, the policy loan interest rate.

By signing below, you agree that you have read the above and received a copy of this disclosure form.

Date

Owner's (Applicant's) Signature

Agent's Signature

IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.