



Application for Fixed Life Insurance

MAIL TO:

4333 Edgewood Road NE,
Cedar Rapids, Iowa 52499
1-800-597-7750

THIS APPLICATION PREPARED FOR

Application Prepared by

Broker/Dealer

SECTION 1. PROPOSED PRIMARY INSURED/OWNER										Specified Amount \$ _____	
1. Last Name					First Name				M.I.		
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Years at Address		4. Home Phone ()		5. Driver License Number			State		
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age	9. Place of Birth – State/Country			10. Social Security Number			
11. Height ft in		12. Weight lbs	13. Marital Status		14. Employer				Years		
15. Employer's Address and Phone Number											
16. Occupation & Duties											
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____											
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile											
SECTION 2. PROPOSED ADDITIONAL INSURED										Specified Amount \$ _____	
If more than one Additional Insured, please use Additional Insured Supplement. We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy											
1. Last Name					First Name				M.I.		
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Years at Address		4. Home Phone ()		5. Driver License Number			State		
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age	9. Place of Birth – State/Country			10. Social Security Number			
11. Height ft in		12. Weight lbs	13. Marital Status		14. Relationship to proposed Primary Insured						
15. Employer's Name, Address and Phone Number											
16. Occupation & Duties										# Years	
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____											
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile											
SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED											
If ownership is corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.											
1. Last Name					First Name				M.I.		
2. Address (Cannot be a P.O. Box)					Apt#		City				
State	Zip Code	3. Home Phone ()			4. Social Security Number / Tax ID #						
5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Date of Birth/Trust Date MM-DD-YYYY		7. Relationship to the proposed Primary Insured							
8. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ Type of VISA _____											
SECTION 4. CHILDREN'S BENEFIT RIDER										Specified Amount \$ _____	
Name		Relationship			Date of Birth			Height		Weight	
					M M — D D — Y Y Y Y			ft in		lbs	
					M M — D D — Y Y Y Y			ft in		lbs	
					M M — D D — Y Y Y Y			ft in		lbs	
Are all children listed? <input type="checkbox"/> Yes <input type="checkbox"/> No Are children living with proposed Primary Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If not, explain why: _____											

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If ownership or beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If ownership or beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total			1 0 0

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total			1 0 0

SECTION 7. PROPOSED PLAN OF INSURANCE

WRL Freedom Index UL WRL Lifetime
 WRL Term Plus w/ROP 20 30
 WRL Term Plus 10 15 20 30

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

Guideline Premium Test
 Cash Value Accumulation Test (CVAT)

SECTION 8. DEATH BENEFIT OPTION (if applicable)

Level Benefit Increasing Benefit

SECTION 10. ADDITIONAL BENEFITS—PRIMARY INSURED ONLY Not all applicable with all products.

Base Insured Rider \$ _____, _____ . _____ Disability Waiver of Premium Rider
 Accidental Death Benefit Rider \$ _____, _____ . _____ Critical Illness Rider
 Disability Income Rider Other _____
 (monthly benefit) \$ _____, _____ . _____ Other _____
 Disability Waiver of Monthly Deductions Rider Other _____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... \$ _____, _____ . _____

Single Premium Annually Semiannually Quarterly Monthly Other _____
 Electronic (bank draft) _____ Draft Date (1st thru 28th)
 Direct Bill

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100%.

_____ .0% Index Account
 _____ .0% Basic Interest Account
 _____ **100%** **Total**

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts? Yes No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?	
					Yes	No
					Yes	No
					Yes	No
					Yes	No

IS THIS INTENDED TO BE A 1035 EXCHANGE? Yes No

Anticipated Cash Value Transfer \$ _____, _____ . _____

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ Yes No

B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. Yes No

C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. Yes No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed Primary Insured, not the Owner.

- A) Gross Income Current Yr \$ _____ , _____ . _____
- B) Gross Income Previous Yr \$ _____ , _____ . _____
- C) Source of Funds Employment Retirement Inheritance 1035 Exchange Other _____
- D) Current Net Worth \$ _____ , _____ . _____

For over \$1,000,000.00 applied coverage complete a separate Financial Questionnaire.

SECTION 15. BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

- A) Current Estimated Market Value \$ _____ , _____ , _____
- B) Assets
 - Liquid* \$ _____ , _____ , _____
 - Nonliquid* \$ _____ , _____ , _____
- C) Liabilities \$ _____ , _____ , _____
- D) Net Worth \$ _____ , _____ , _____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to “No” answer for medical question 16A and “Yes” answers to questions 16B-E in Section 17 below:

- A) For the last 180 days has the proposed Primary Insured been actively at work, on a full time basis, at their usual place of business or employment? Yes No
- B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:
 - 1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? Yes No
 - 2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? Yes No
 - 3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? Yes No
 - 4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? Yes No
 - 5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? Yes No
- C) To the best of your knowledge, has any proposed Insured within the last 10 years:
 - 1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? Yes No
 - 2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? Yes No
 - 3) Been on or are now on prescribed medication or prescribed diet? Yes No
 - 4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI’s or other test? Yes No
 - 5) Had an examination, treatment or consultation with a doctor or health care provider other than above? Yes No
- D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? Yes No
- E) Has the proposed Primary Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? Yes No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured’s Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of USA Other Country _____ Type of VISA _____

B) How many years has the proposed Insured resided in the USA? _____

C) Does any proposed Insured travel outside the USA? Yes No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year. _____

SECTION 20. DRIVING AND PUBLIC RECORDS – Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? Yes No If yes, include name of proposed Insured and give reason: _____

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? Yes No If yes, include name of proposed Insured and give reason: _____

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. Yes No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. Yes No

SECTION 22. TRANSFER AUTHORIZATION–TO BE COMPLETED BY APPLICANT/OWNER (only for IUL)

Transfer Authorization:

Your policy applied for, if issued, will automatically receive transfer privileges, unless declined below. These privileges only allow the Owner and agent of record to change premium allocations and transfer between the Basic Interest Account and the Index Account. Transfers are subject to the restrictions/guidelines outlined in the Statement of Understanding.

Western Reserve Life Assurance Co. of Ohio will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Western Reserve Life Assurance Co. of Ohio will employ reasonable procedures to confirm that transfer instructions are genuine. If Western Reserve Life Assurance Co. of Ohio does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

The agent does **not** have authority to make transfers or change payment allocations on my behalf.

SECTION 23. OTHER INSURANCE–TO BE COMPLETED BY THE AGENT

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? Yes No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? Yes No
(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? Yes No

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CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months the proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the conditional receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of \$ _____ for the insurance application dated _____, with _____ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if the proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or \$500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)

I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____
City, State Date Signature of Agent or Authorized Company Rep

Signature of proposed Insured

Signature of Applicant (if other than proposed Insured)

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, 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 a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, 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. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Western Reserve Life Assurance Co. of Ohio, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

**PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED
IF NOT A HOUSEHOLD MEMBER.**

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Additional Insured Supplement

SECTION 1. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State	Zip Code	3. Years at Address	4. Home Phone ()			5. Driver License Number			State	
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										
SECTION 2. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State	Zip Code	3. Years at Address	4. Home Phone ()			5. Driver License Number			State	
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										
SECTION 3. PROPOSED ADDITIONAL INSURED										SPECIFIED AMOUNT \$ _____
We will allow the AIR death benefit recipient to be a choice of: <input type="checkbox"/> Owner <input type="checkbox"/> Primary Insured <input type="checkbox"/> Same beneficiary as the base policy										
1. Last Name					First Name				M.I.	
2. Address (Cannot be a P.O. Box)							Apt#		City	
State	Zip Code	3. Years at Address	4. Home Phone ()			5. Driver License Number			State	
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth MM-DD-YYYY		8. Age		9. Place of Birth – State/Country		10. Social Security Number		
11. Height ft in		12. Weight lbs		13. Marital Status		14. Relationship to proposed Primary Insured				
15. Employer's Name, Address and Phone Number										
16. Occupation & Duties										# Years
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____										
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile										

SECTION 4. PROPOSED ADDITIONAL INSURED **SPECIFIED AMOUNT \$ _____**

We will allow the AIR death benefit recipient to be a choice of: Owner Primary Insured Same beneficiary as the base policy

1. Last Name		First Name			M.I.
2. Address (Cannot be a P.O. Box)				Apt#	City
State	Zip Code	3. Years at Address	4. Home Phone ()	5. Driver License Number	State
6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth MM - DD - YYYY		8. Age	9. Place of Birth – State/Country	10. Social Security Number
11. Height ft in	12. Weight lbs	13. Marital Status		14. Relationship to proposed Primary Insured	
15. Employer's Name, Address and Phone Number					
16. Occupation & Duties					# Years
17. Have you used TOBACCO or any other product containing NICOTINE in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last used _____					
18. Rate Class Quoted: <input type="checkbox"/> Preferred Elite <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Tobacco <input type="checkbox"/> Juvenile					

SECTION 5. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ on - -
(city) (state) (date)

sec. 1 _____
 Signature of proposed Additional Insured
 (Child over 15 must sign)

sec. 3 _____
 Signature of proposed Additional Insured
 (Child over 15 must sign)

sec. 2 _____
 Signature of proposed Additional Insured
 (Child over 15 must sign)

sec. 4 _____
 Signature of proposed Additional Insured
 (Child over 15 must sign)

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

 Signature of Applicant/Owner, if other than the
 proposed Primary Insured (If business insurance,
 show title of officer and name of firm. If trust, show
 trustee's name)

 Witness (Registered Representative)

AGENT'S REPORT
(all sections must be completed)

1. **Type of Sale** (check only one box)

- Personal/Family
- Business Planning
- Estate Planning

Supplemental Purpose of Policy (check only one box)

- | | |
|---|---|
| <u>Business</u> | <u>Personal/Family</u> |
| <input type="checkbox"/> Key Employee | <input type="checkbox"/> Mortgage |
| <input type="checkbox"/> Executive Bonus | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Deferred Compensation | <input type="checkbox"/> Education |
| <input type="checkbox"/> Split Dollar | <input type="checkbox"/> Income to Family |
| <input type="checkbox"/> Buy/Sell - Is Partner applying
for similar amount? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Cash Accumulation |
| Name of Partner _____ | <u>Estate Planning</u> |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Estate Liquidity |
| | <input type="checkbox"/> Wealth Replacement |

2. Was this plan sold, presented or illustrated as a single employer welfare benefit plan as defined under IRC Section 419?

- Yes No

If "Yes", have you completed and attached the required Disclosure, Acknowledgment and Release Form? Yes No

3. a) How long have you known the proposed Insured?

b) Relationship to proposed Insured: _____

c) Are you financially responsible for the proposed Insured?

- Yes No

4. Is the proposed Insured or Owner a licensed Representative of any Broker/Dealer? If yes, name and address of Broker/Dealer _____

5. Is the proposed Insured or Owner related to any affiliated Broker/Dealer officer or employee? Yes No

If yes, name and address of Broker/Dealer _____

6. Did you give the "Notice of Information Practices" to the proposed Insured? Yes No

7. Are you submitting or do you plan to submit another application on any proposed Insured listed to WRL or any other company?

- Yes No

Company Name _____

Face amount \$ _____

Total face amount to be placed with all companies \$ _____

8. **Medical Examination**

Are you arranging for the Medical Requirements?

Yes Paramedical Service used: _____

No Request Western Reserve Life Assurance Co. of Ohio order medical requirements.

9. Did you ask all questions in the physical presence of the proposed Insured? Yes No

10. Are you aware of anything about the health, habits, hazardous sports, environment or mode of living, which may affect the insurability of any person proposed for insurance?

- Yes No

11. Financial Information of Applicant/Owner **if other** than the proposed Insured:

Gross Income Current Year: \$ _____

Current Net Worth: \$ _____

12. Did you comply with all requirements relative to obtaining Informed Consent for HIV and AIDS testing? Yes No

13. Identification Verification

Identification was viewed during face to face sale? Yes No

Type of Government issued photo ID _____

Issuer of Identification Document _____

Number _____ Expiration Date _____

14. Is the Agent or Split Agent also the Owner, Applicant or Payor?

- Yes No

15. Writing Agent Name _____

Agent No. _____

Agent's Telephone Number _____

Agent's Fax Number _____

Agent's E-Mail _____

Percent of Agent's Split _____

Split Agent Name _____

Agent No. _____ Percent of Agent's Split _____

16. Was money taken with the application?

- Yes No

If "yes", was the Conditional Receipt completed and given to the applicant? Yes No

17. If proposed Insured is a juvenile (ages 0 through 15):

(a) Did you personally see child? Yes No

(b) Does child live with parents? Yes No

(If "No," explain) _____

(c) Life insurance in force on father's life? Yes No

If yes, list amount _____

Life insurance in force on mother's life? Yes No

If yes, list amount _____

(d) Life insurance applied for or in force on brothers and sisters? Yes No

If yes, list amount(s) _____

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

\$ _____ has been paid by the Applicant with this application.

Signature of Writing Agent

Date

AG 0807 Std

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PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN

Authorization to Insurance Company

The Premium Payor hereby authorizes Western Reserve Life Assurance Co. of Ohio 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 Administrative Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing below.

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 Western Reserve Life Assurance Co. of Ohio 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.

Initial Payment (Must Check One Box)

- CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.
- AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

Account Information

TAPE VOIDED CHECK HERE

If not attaching void check or if withdrawing from Savings Account, complete the following information

Bank Name, Office or Branch _____

Payor Name(s) _____ Check one: Checking Savings

Transit Routing Number _____ Account Number _____

Complete the Following Information for Future Recurring Payments

Premium to Withdraw	<input type="checkbox"/> Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
\$ _____	<input type="checkbox"/> Withdraw on a different day of the month; choose a day between 1 and 28 _____

Signature

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

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 1-800-851-9777

Or Write: Western Reserve Life Assurance Co. of Ohio, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

- 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
ARIZONA**

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. *HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.*

Persons most at risk of contracting HIV are men who have sex with other men; intravenous (“IV”) drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-test Counseling Considerations

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department or:

Phoenix metropolitan area: 602-253-2437
(Arizona AIDS Information Line)

Outside the Phoenix area: 1-800-334-1540
(Arizona Department of Health Services)

Disclosure of Test Results

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. Section 20-448.01.

Meaning of Positive Test Results

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body’s immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

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 testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that the provisions of this consent form shall be effective for a period not to exceed 180 days from the date this form was signed by me or my legal representative.

Proposed Insured (Please Print)

Date of Birth

Signature of Proposed Insured or Parent/Guardian

Date Signed

Optional Release of Information to Personal Physician

In addition to the release of information as described above, I hereby authorize the release of my lab test results to my personal physician named below:

Physician’s Name

Physician’s Address

Phone Number

City, State, Zip

Signature of Proposed Insured or Parent/Guardian

Date Signed

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 and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the 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. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
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.

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 and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the 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. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
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**
4333 Edgewood Rd. N.E./ Cedar Rapids, Iowa 52499
(319) 398-8511
- Western Reserve Life Assurance Co. of Ohio**
P.O. BOX 5068/ Clearwater, Florida 33758
(800) 624-2975
- Transamerica Life Insurance Company**
4333 Edgewood Rd. N.E./ Cedar Rapids, Iowa 52499
(319) 398-8511

- People's Benefit Life Insurance Company**
4333 Edgewood Rd. N.E./ Cedar Rapids, Iowa 52499
(319) 398-8511
- Monumental Life Insurance Company**
4333 Edgewood Rd. N.E./ Cedar Rapids, Iowa 52499
(319) 398-8511

**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

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

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

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

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

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

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

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

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

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

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

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name _____ Date

Producer's Signature and Printed Name _____ Date

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

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

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expenses and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

30 DAY RIGHT TO CANCEL

In the event of a replacement transaction you may cancel this policy or contract by delivering or mailing a written request to us or to the agent from whom it was purchased. You must return the policy or contract to us or the agent before midnight of the thirtieth day after the day you receive it. Your written request given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid. We must provide a full unconditional refund of all premiums or considerations paid on this policy or contract, including any policy or contract fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract.



Western Reserve Life Assurance Co. of Ohio
Replacement Transaction(s) Sales Material Certification

Print Agent Name and Code: _____

Print Applicant Name: _____

I hereby certify that:

- I have used only Western Reserve Life Assurance Co. of Ohio approved sales material.
- I have given a copy of all sales material used during the presentation to the applicant, including printed copies of any electronically presented sales materials.
- I have advised the customer of the importance of retaining copies of the sales material for future reference.

AGENT SIGNATURE

DATE

PRE-AUTHORIZED PAYMENT PLAN

**ACADEMY LIFE INSURANCE COMPANY • LIFE INVESTORS INSURANCE COMPANY OF AMERICA
 MONUMENTAL LIFE INSURANCE COMPANY • PENSION LIFE INSURANCE COMPANY OF AMERICA
 PEOPLES BENEFIT LIFE INSURANCE COMPANY • TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY
 TRANSAMERICA LIFE INSURANCE COMPANY • WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
 4333 EDGEWOOD ROAD N.E. • CEDAR RAPIDS, IOWA 52499-0001**

As a convenience to me, I request and authorize the Company to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same and to charge the same to my account. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect not to receive notice if such entry is equal to the amount due the Company. This Authorization will remain in effect until I notify the Company or the financial institution in writing to terminate and the Company or the financial institution has a reasonable time to act on the termination. I hereby terminate any prior Authorization of the Company to initiate charges to this account, effective the date on which the initial charge is initiated by the Company under this Authorization. I understand that I may stop any charge by notifying the financial institution before my account is charged, and I may have the amount of the erroneous electronic debit entry credited to my account within 15 days after issuance of my statement or 45 days after posting, whichever occurs first.

PLEASE COMPLETE, SIGN AND RETURN IN ENCLOSED ENVELOPE.

Name of Bank or Credit Union Where Account is Authorized		Routing #	Policy Number _____ Policy Number _____ Policy Number _____
Address of Bank		Bank Telephone Number	Depositor's Account Number _____
		<input type="checkbox"/> Checking <input type="checkbox"/> Savings	
City	State	Zip Code of Bank	Draw <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Day to Draw: _____
Signature of Depositor		Date	Name of Insured (Print)

Attach Check Here

What is the Automatic Deduction Plan and How Does It Work?

It's a convenient way to pay your insurance premiums through automatic deductions from your checking or savings account. You choose the day most convenient for you to draw from your account between ***the 1st and 28th day of each month***. Attach a void check from the bank account where payments will be deducted.



Pre-Authorized Payment Plan Additional Information

What is the Automatic Deduction Plan?

It is a convenient way to pay monthly insurance premiums through automatic deductions from your checking account. It eliminates extra paperwork, monthly postage, and misplaced bills.

How Does It Work?

You choose the preparation day most convenient for you between the 1st and 28th day of each month. Each month we prepare a debit for your account and send it directly to your bank. The bank deducts the amount from your checking account shortly thereafter. The debit should appear on your next bank account statement.

What if I move or I Change Bank Accounts?

To assure continued payment, a 10-day advance notice is advised. We will need a new authorization form from, and a blank, void check from your new account.

How Can I Change to Direct Billing?

We will need a 10-day advance written notice to change your payment method from the Automatic Deduction Plan to Direct Billing. We will notify you of the change and send a premium notice to help assure continued coverage.

What if my Deduction is Returned Unpaid?

To prevent unpaid deductions, please note all deductions in your checking account register.

You will be notified if any deduction is not honored by your bank. Automatic deduction will be stopped immediately and we will contact you regarding replacement premium and the future billings on your policy.

Here is How to Enroll:

Complete the enclosed authorization form. Enclose a blank, unsigned, void check from the bank account where monthly payments will be deducted. Mail forms and void check in the envelope provided.

Keep this as a reminder of your current deduction, and update it as necessary.

Policy/certificate # _____ \$ _____

Policy/certificate # _____ \$ _____

Policy/certificate # _____ \$ _____

Total Deducted Monthly \$ _____

Monthly Deduction Day _____