



# *Application for Fixed Life Insurance*

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**MAIL TO:**

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

**THIS APPLICATION PREPARED FOR**

\_\_\_\_\_  
Application Prepared by

\_\_\_\_\_  
Broker/Dealer



<b>SECTION 1. PROPOSED PRIMARY INSURED/OWNER</b>										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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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											
<b>SECTION 2. PROPOSED ADDITIONAL INSURED</b>										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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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											
<b>SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED</b>										Specified Amount \$ _____	
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 _____											
<b>SECTION 4. CHILDREN'S BENEFIT RIDER</b>										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 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, sugar, albumin, blood or pus 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 (not including HIV test or 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

**SECTION 24. ILLUSTRATION CERTIFICATION** The box below **MUST** be checked if a signed illustration of the policy (if applicable) applied for is **NOT** enclosed with this application.

The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:  
**Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

**SECTION 25. TAXPAYER IDENTIFICATION CERTIFICATION**

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 26. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed owner must have personally received and accepted the policy during the lifetime of all proposed insured(s) and while all proposed insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Western Reserve Life Assurance Co. of Ohio, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Western Reserve Life Assurance Co. of Ohio to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Western Reserve Life Assurance Co. of Ohio to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

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.

**I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, and (3) Notice of Insurance Information Practices.**

**I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.**

Signed at \_\_\_\_\_ (city) \_\_\_\_\_ (state) on MM - DD - YYYY (date)

Signature of proposed Primary Insured/Owner (Child over age 15 must sign) \_\_\_\_\_ Print Agent Name \_\_\_\_\_

Signature of parent or legal guardian for Insured(s) 15 and under \_\_\_\_\_ Agent # \_\_\_\_\_

Signature of proposed Additional Insured \_\_\_\_\_

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) \_\_\_\_\_ Signature of Agent/Licensed Rep. \_\_\_\_\_

Signature of Split Agent/Licensed Rep. \_\_\_\_\_

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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;
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

<b>SECTION 1. PROPOSED ADDITIONAL INSURED</b>										<b>SPECIFIED AMOUNT \$ _____</b>	
<b>We will allow the AIR death benefit recipient to be a choice of:</b> <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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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											
<b>SECTION 2. PROPOSED ADDITIONAL INSURED</b>										<b>SPECIFIED AMOUNT \$ _____</b>	
<b>We will allow the AIR death benefit recipient to be a choice of:</b> <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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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											
<b>SECTION 3. PROPOSED ADDITIONAL INSURED</b>										<b>SPECIFIED AMOUNT \$ _____</b>	
<b>We will allow the AIR death benefit recipient to be a choice of:</b> <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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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 <b>TOBACCO</b> or any other product containing <b>NICOTINE</b> 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 MM - DD - YYYY  
 (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)

Business

- Key Employee
- Executive Bonus
- Deferred Compensation
- Split Dollar
- Buy/Sell - Is Partner applying for similar amount?  Yes  No
- Name of Partner \_\_\_\_\_
- Other \_\_\_\_\_

Personal/Family

- Mortgage
- Retirement
- Education
- Income to Family
- Cash Accumulation

Estate Planning

- Estate Liquidity
- 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 an application on any proposed Insured on this application to 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 reqs.

9. Did you ask all questions in the 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 \_\_\_\_\_

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

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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**

<b>TAPE VOIDED CHECK HERE</b>	
<b>If not attaching void check or if withdrawing from Savings Account, complete the following information</b>	
Bank Name, Office or Branch	
Payor Name(s)	Check one: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Transit Routing Number	Account Number

**Complete the Following Information for Future Recurring Payments**

<b>Premium to Withdraw</b>	<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**

<b>Payor Signature(s)</b> – 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

<b>Notice and Consent for HIV-Related Testing CALIFORNIA</b>
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Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

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 HIV antibodies. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection. By signing and dating this Consent, you agree that this test may be done.

### **The HIV Antibody Test**

A series of tests will be performed by a licensed laboratory through a medically accepted procedure. The most commonly used tests are the ELISA or "EIA" and the Western blot. If the ELISA shows the sample is positive for HIV, then the Western blot is done to confirm that initial result.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally the test may be negative in persons who are infected with HIV.

### **Meaning of Test Results**

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 test 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.

### **Counseling**

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. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or health care provider. A list of counseling resources is provided for your information. Other counseling services may also be available to you.

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

**Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting or claims decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer. Negative test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results 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 specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

**Notification of Test Results**

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your physician or health care provider so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal & Confidential", at your residence address.

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Street

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip Code

**Other Sources of Information**

As required by California law, the following list of counseling resources is being provided to you.

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.

**HIV/AIDS HOTLINE - National**

(800) 342-2437 English  
(800) 222-9432 Spanish  
(800) 243-7889 TTY/TDD users

**AIDS HOTLINE WEB SITE**

<http://www.aidshotline.org>

**HIV/AIDS HOTLINE - California**

(800) 367-2437 English, Spanish & Filipino  
(888) 225-2437 TTY users

**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 provide a sample of my bodily fluid(s), the testing of my bodily fluid(s) for HIV antibodies, and disclosure of the test results as described.**

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.

\_\_\_\_\_  
Proposed Insured (*Please Print*)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured

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

## **NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY For Distribution by Insurers, Agents, and Brokers**

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

### **Recovery**

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

### **Unmarried Resident**

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than \$2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of \$35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

### **Married Resident**

*Community spouse resource allowance:* If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than \$94,540.

*Minimum monthly maintenance needs allowance:* If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income or \$2,489 in monthly income, whichever is greater.

### **Fair Hearings and Court Orders**

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$94,540 in countable resources. The order also may allow the at-home spouse to retain more than \$2,489 in monthly income.



## Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

### Real Property Exemptions

- *One principal residence.* One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- *Real property used in a business or trade.* Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

### Personal Property and Other Exempt Assets

- *IRAs, KEOGHs, and other work-related pension plans.* These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal property used in a trade or business.*
- *One motor vehicle.*
- *Irrevocable burial trusts or irrevocable prepaid burial contracts.*

*There may be other assets that may be exempt.*

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

**Please note:** The Federal Government has authorized the State of California, Department of Health Services (DHS) to seek repayment from annuities held by deceased Medi-Cal beneficiaries. The Department may seek repayment from the estate of a deceased Medi-Cal beneficiary for the expenses incurred for all premium payments and services received by the beneficiary's 55<sup>th</sup> birthday. Premium payments made by the State include, but are not limited to, dental premiums, Medicare premiums, and premium payments made to Medi-Cal managed care plans.

In addition, if you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

\_\_\_\_\_  
Purchaser signature Date

➤ \_\_\_\_\_  
Spouse's signature Date

➤ \_\_\_\_\_  
Legal representative signature Date

➤ \_\_\_\_\_

- 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

**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 to not more than 12 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.

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.

**RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.**

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.**

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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **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 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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **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 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.

## 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 \_\_\_\_\_