



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										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 _____										

SECTION 4. CHILDREN'S BENEFIT RIDER										Specified Amount \$ _____	
Name		Relationship			Date of Birth			Height		Weight	
					MM-DD-YYYY			ft in		lbs	
					MM-DD-YYYY			ft in		lbs	
					MM-DD-YYYY			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, 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

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

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 (24 months in Iowa, Kentucky, New Mexico and Wyoming) 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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FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

For applicants in **ARKANSAS, LOUISIANA and WEST VIRGINIA**

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

Applicant's Signature _____ Date _____

For applicants in **COLORADO**

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

Applicant's Signature _____ Date _____

For applicants in **DISTRICT OF COLUMBIA**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicant's Signature _____ Date _____

For applicants in **FLORIDA**

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

Applicant's Signature _____ Date _____

For applicants in **KENTUCKY**

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

Applicant's Signature _____ Date _____

For applicants in **MAINE and TENNESSEE**

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

Applicant's Signature _____ Date _____

For applicants in **NEW JERSEY**

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

Applicant's Signature _____ Date _____

For applicants in **NEW MEXICO**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicant's Signature _____ Date _____

For applicants in **OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant's Signature _____ Date _____

For applicants in **OKLAHOMA**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicant's Signature _____ Date _____

For applicants in **PENNSYLVANIA**

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

Applicant's Signature _____ Date _____

For applicants in **PUERTO RICO**

Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars (\$5000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Applicant's Signature _____ Date _____

For applicants in **VIRGINIA and WASHINGTON**

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

Applicant's Signature _____ Date _____

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CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any 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, 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 a 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	
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15. Employer's Name, Address and Phone Number											
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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											

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)

<p><u>Business</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Key Employee <input type="checkbox"/> Executive Bonus <input type="checkbox"/> Deferred Compensation <input type="checkbox"/> Split Dollar <input type="checkbox"/> Buy/Sell - Is Partner applying for similar amount? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Partner _____ <input type="checkbox"/> Other _____ 	<p><u>Personal/Family</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Mortgage <input type="checkbox"/> Retirement <input type="checkbox"/> Education <input type="checkbox"/> Income to Family <input type="checkbox"/> Cash Accumulation <p><u>Estate Planning</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Estate Liquidity <input type="checkbox"/> Wealth Replacement
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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.

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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) _____

Transit Routing Number _____

Account Number _____

Check one: Checking Savings

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

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

Peoples Benefit Life Insurance Company
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 34618
(800) 624-2975

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

Transamerica Life Insurance Company
4333 Edgewood Rd. N.E./ Cedar Rapids, Iowa 52499
(319) 398-8511

IMPORTANT NOTICE REGARDING THE REPLACEMENT OF YOUR POLICY OR LIFE INSURANCE

You have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy you should consider whether you could suffer a Financial Loss under the new policy because of your Age or the condition of your Health. You should also consider whether you will pay more for premiums because of your age or health.

You will incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides 10 days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, he will be notifying your existing insurance company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

Applicant _____

Date _____

Agent _____

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 _____