

<i>SERFF Tracking Number:</i>	<i>NDPL-125760216</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aviva Life and Annuity Company</i>	<i>State Tracking Number:</i>	<i>40082</i>
<i>Company Tracking Number:</i>	<i>2CIBUA09</i>		
<i>TOI:</i>	<i>L09I Individual Life - Flexible Premium Adjustable Life</i>	<i>Sub-TOI:</i>	<i>L09I.001 Single Life</i>
<i>Product Name:</i>	<i>Children's Insurance Rider</i>		
<i>Project Name/Number:</i>	<i>2CIBUA09/2CIBUA09</i>		

## Filing at a Glance

Company: Aviva Life and Annuity Company

Product Name: Children's Insurance Rider

TOI: L09I Individual Life - Flexible Premium

Adjustable Life

Sub-TOI: L09I.001 Single Life

Filing Type: Form

SERFF Tr Num: NDPL-125760216 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40082

Co Tr Num: 2CIBUA09

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Authors: Angela Vennall, Dana  
Kelly

Disposition Date: 08/28/2008

Date Submitted: 08/27/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 2CIBUA09

Project Number: 2CIBUA09

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 08/25/2008

Domicile Status Comments: Approved by  
domiciliary state, Iowa, effective 8/25/08

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/28/2008

State Status Changed: 08/28/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your approval is our Children's Insurance Rider, Form 2CIBUA09.

This individual universal life rider form has been revised to comply with the 2001 Commissioner's Standard Ordinary Mortality Table regulations. The rider will be available with UL base products compliant with the 2001 CSO Mortality

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
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Company Tracking Number: 2CIBUA09  
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Adjustable Life  
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Project Name/Number: 2CIBUA09/2CIBUA09

Table regulation.

This form is an optional benefit rider which is designed to provide term insurance coverage on each of the Insured's eligible children. The term insurance expires when the Insured Child reaches the age of 25. This Rider generates cash values.

This form replaces form number 21032F02, approved by your Department on May 1, 2002.

This Rider is intended for the general market and will be individually solicited through licensed agents. The issue ages are: 16-55, Age Nearest Birthday, for the primary insured and 15 days to 17 years for the child.

A sample data page is enclosed to demonstrate how the benefit description will be shown.

This form is written in simplified and readable language and does not contain any unusual or possibly controversial items from normal company or industry standards.

This form has been produced from our Automated Policy Assembly Laser system and is in final print.

You may direct any questions or comments regarding this submission to me at (800) 457-3557, ext. 6747 or e-mail me at [dana.kelly@avivausa.com](mailto:dana.kelly@avivausa.com).

## Company and Contact

### Filing Contact Information

Dana Kelly, Product Compliance Specialist [dana.kelly@avivausa.com](mailto:dana.kelly@avivausa.com)  
Indianapolis Life Insurance Company (317) 927-6747 [Phone]  
Indianapolis, IN 46240 (317) 927-6510[FAX]

### Filing Company Information

Aviva Life and Annuity Company CoCode: 61689 State of Domicile: Iowa  
611 Fifth Avenue Group Code: 1225 Company Type:  
Des Moines, IA 50309 Group Name: State ID Number:

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
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Adjustable Life  
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(317) 927-6749 ext. [Phone]

FEIN Number: 42-0175020

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SERFF Tracking Number: NDPL-125760216 State: Arkansas  
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Adjustable Life  
Product Name: Children's Insurance Rider  
Project Name/Number: 2CIBUA09/2CIBUA09

## Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation: 1 Rider x \$20.00 = \$20.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aviva Life and Annuity Company	\$20.00	08/27/2008	22159287

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
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Adjustable Life  
Product Name: Children's Insurance Rider  
Project Name/Number: 2CIBUA09/2CIBUA09

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	08/28/2008	08/28/2008

*SERFF Tracking Number:* NDPL-125760216      *State:* Arkansas  
*Filing Company:* Aviva Life and Annuity Company      *State Tracking Number:* 40082  
*Company Tracking Number:* 2CIBUA09  
*TOI:* L09I Individual Life - Flexible Premium      *Sub-TOI:* L09I.001 Single Life  
Adjustable Life  
*Product Name:* Children's Insurance Rider  
*Project Name/Number:* 2CIBUA09/2CIBUA09

## **Disposition**

Disposition Date: 08/28/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
 Filing Company: Aviva Life and Annuity Company State Tracking Number: 40082  
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 Adjustable Life  
 Product Name: Children's Insurance Rider  
 Project Name/Number: 2CIBUA09/2CIBUA09

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification		No
<b>Supporting Document</b>	Outline of Coverage		No
<b>Supporting Document</b>	CI Actuarial Memorandum		No
<b>Supporting Document</b>	CI Sample Data Page		Yes
<b>Form</b>	Children's Insurance Rider		Yes

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
 Filing Company: Aviva Life and Annuity Company State Tracking Number: 40082  
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 Project Name/Number: 2CIBUA09/2CIBUA09

## Form Schedule

Lead Form Number: 2CIBUA09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	2CIBUA09	Policy/Cont	Children's Insurance Rider	Initial		51	CIBUA09.PDF
			al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider				



## **Aviva Life and Annuity Company**

[Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309]  
[Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309]  
[1-800-800-9882]

### **CHILDREN'S INSURANCE RIDER**

Attached to and made a part of this policy

We agree to provide the term insurance benefits of this rider upon receipt of due proof of the death of an Insured Child. These benefits are subject to the provisions, terms and conditions of this rider and the policy to which it is attached. This rider is issued in consideration of the application received and the payment of the cost for this benefit.

Insurance on the life of each Insured Child will be term insurance for the amount shown on the Policy Data Page. This insurance expires on the Insured Child's 25th birthday or on this rider's expiry date, whichever is earlier.

#### **INSURED CHILD**

An Insured Child under this rider is any child at least 15 days old who is:

- a) any child, stepchild or legally adopted child of the Insured who is named in the application for this rider and has not reached age 18 on the date of the application;
- b) any child born to the Insured after the rider date; and
- c) any child legally adopted by the Insured after the rider date.

#### **BENEFICIARY PROVISION**

During the Insured's lifetime, the beneficiary of this rider shall be the Owner under the policy unless specified otherwise in the application or changed as provided in the policy and this rider. Written notice of any beneficiary change for any Insured Child must be filed with us while the Insured Child is living.

#### **COST**

The cost for this rider is determined on a monthly basis. This cost will be included in the monthly deduction from the policy Account Value and is not payable after this rider is terminated. We calculate the monthly cost for the rider as:

- a) the amount of term insurance for this rider as shown on the Policy Data Page, divided by 1,000; multiplied by
- b) \$0.60.

#### **REINSTATEMENT**

You may reinstate this rider at any time within five years after the end of the grace period, provided the policy to which it is attached is also reinstated.

The requirements for reinstatement are:

- a) submit an application for reinstatement;
- b) submit evidence of insurability satisfactory to us for each Insured Child to be reinstated; and
- c) pay a minimum premium sufficient to keep the policy and this rider in force for two months.

For each Insured Child meeting the above requirements, reinstatement of this rider will be effective on the date of reinstatement of the policy. The incontestability provision will apply from the date of reinstatement for each Insured Child. If the rider has been in force for two years during the Insured Child's lifetime, it will be contestable only as to statements made in the reinstatement application.

### **CONVERSION PRIVILEGE**

When any term insurance on the life of an Insured Child expires, it may be converted to a new policy without evidence of insurability. The amount of insurance for a new policy on an Insured Child may not exceed five times the amount expiring under this rider and may not be less than the minimum for the plan selected. The effective date of the new policy will be the date the term insurance expires.

### **THE NEW POLICY**

The requirements for conversion are:

- a) this rider must be in force on the date the coverage for an Insured Child expires;
- b) you must submit an application for the new policy and pay the first premium during the lifetime of the Insured Child and within 31 days after the coverage for the Insured Child expires; and
- c) the new policy may be any single life permanent plan of insurance which qualifies under our rules in effect on the policy date of the new policy.

Premiums and values for the new policy will be based on:

- a) a rate class most comparable to the Insured Child's rate class under this rider;
- b) rates in effect on the date of exchange; and
- c) the Insured Child's attained age nearest birthday on the date of conversion.

### **DEATH DURING CONVERSION PERIOD**

If an Insured Child having the right to convert should die within the 31-day conversion period without having exercised the right, we will pay a death benefit equal to the amount of term insurance expiring on the child's life. This benefit will be paid to the applicable beneficiary as of the date of expiry, upon receipt of satisfactory proof of the death.

### **PAID-UP TERM INSURANCE BENEFIT**

If the Insured should die while this rider is in force, any term insurance then in force under this rider will continue as paid-up term insurance until the term insurance would normally have expired on each Insured Child.

This paid-up term insurance may be surrendered for its cash value upon your written request. The cash value of the paid-up term insurance within 30 days after a policy anniversary will not be less than the value on the anniversary. The cash value will be the net single premium of all future guaranteed benefits at the attained age of each Insured Child covered as of the date of surrender, assuming the following:

- a) the 2001 Commissioner's Standard Ordinary Mortality Table;
- b) continuous functions;
- c) interest at the Guaranteed Interest Rate as shown on the Policy Data Page; and
- d) attained age nearest birthday.

Information regarding the cash value will be furnished by us upon request.

### **INCONTESTABILITY**

All statements made in the application or supplemental applications are considered representations and not warranties. No statement with regard to any Insured Child will be used to void this rider or to defend against a claim unless contained in the application, supplemental applications, or any amendments attached to the policy at issue or made part of the policy when a change becomes effective. The validity of this rider will not be contestable as to any Insured Child after it has been in force for two years during such Insured Child's lifetime except for non-payment of premiums sufficient to keep the rider in force.

**SUICIDE**

If the Insured or an Insured Child commits suicide, while sane or insane, during the first two years this rider is in force, our liability will be limited to the monthly deductions made from the policy to cover the monthly cost for this rider. The rider will then terminate.

**MISSTATEMENT OF AGE**

If the birth date of an Insured Child has been misstated, all rights and liabilities with respect to the child will be in accordance with the correct birth date and age of the child.

**TERMINATION**

This rider will terminate on the earliest of the following dates and events:

- a) if any premium due to cover the monthly deduction for this rider or policy remains unpaid at the end of its grace period;
- b) when the policy is exchanged for another policy, matures, becomes paid-up in any manner or terminates for any reason other than death of the Insured;
- c) our receipt of your written request for termination of this rider; and
- d) the expiry date of the rider as shown on the Policy Data Page or endorsement.

**EFFECTIVE DATE**

The effective date of this rider will be the Policy Date unless a later effective date is shown on the Policy Data Page or endorsement.



Michael H. Miller  
Secretary

*SERFF Tracking Number:* NDPL-125760216      *State:* Arkansas  
*Filing Company:* Aviva Life and Annuity Company      *State Tracking Number:* 40082  
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*TOI:* L09I Individual Life - Flexible Premium      *Sub-TOI:* L09I.001 Single Life  
Adjustable Life  
*Product Name:* Children's Insurance Rider  
*Project Name/Number:* 2CIBUA09/2CIBUA09

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: NDPL-125760216 State: Arkansas  
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Adjustable Life  
Product Name: Children's Insurance Rider  
Project Name/Number: 2CIBUA09/2CIBUA09

## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice 08/04/2008

#### Comments:

Attached are: Guarantee Association Notice, Policyowner Notice, Readability Certification, Reg 19 Certification, and Reg 49 Certification.

#### Attachments:

AR1703.PDF  
AR1705.PDF  
AR RDCRT - Aviva.pdf  
ARreg19\_Aviva.pdf  
ARreg49\_ALAC.pdf

### Review Status:

**Satisfied -Name:** Application 08/04/2008

#### Comments:

Copies of the Application and TeleApp Application used to apply for this rider are attached - Form 14530 2/07 and Form 15094 2/07. They were approved by your Department on 8/28/06.

#### Attachments:

14530\_2-07.pdf  
15094\_2-07.pdf

### Review Status:

**Satisfied -Name:** CI Sample Data Page 08/04/2008

#### Comments:

CI Sample Data Page is attached.

#### Attachment:

CI Sample Data Page.pdf



# AVIVA

## Aviva Life and Annuity Company

Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309

Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309

1-800-800-9882

### APPENDIX A

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of this Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capital  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

## **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



# AVIVA

## Aviva Life and Annuity Company

Home Office: 611 Fifth Avenue, Des Moines, Iowa 50309  
Administrative Office: 611 Fifth Avenue, Des Moines, Iowa 50309  
1-800-800-9882

TO: Aviva Life Policyowner

FROM: Aviva Life and Annuity Company

Bulletin number 6-87, Act 197 of 1987 from the Arkansas Department of Insurance requires effective January 1, 1988 that we provide you with information on our Company, our Agent servicing your policy and on the Arkansas Department of Insurance. Listed below are the names and addresses in the event you would like to contact one of us for more information on your policy.

Aviva Life and Annuity Company  
611 5th Avenue  
Des Moines, IA 50309

Telephone: 1-800-800-9882

Agent Name: XX

Agent Address: XX  
XX

XX

Agent Telephone: XXXXXXXXXXXXXXXX

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1904

Telephone: 1-800-852-5494

AR

**ARKANSAS READABILITY CERTIFICATION**

**This is to certify that the attached, Form 2CIBUA09 – Children’s Insurance Rider, has achieved a Flesch Reading Ease Score of 51.3 and complies with the requirements of Arkansas Statute Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.**

**Aviva Life and Annuity Company**



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**Chris Guttin**  
**ASA / Vice President-Product Operations**

**August 27, 2008**

**Date**

**RD/CRT/AR**

**Arkansas Certification  
Regulation 19**

**I certify that this submission meets the provisions of Regulation 19, Section 10B, as well as all applicable statutes, regulations, and bulletins of the State of Arkansas.**

**Aviva Life and Annuity Company**



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**Chris Guttin, ASA  
Vice-President-Product Operations**

**08/27/2008**

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**Date**

**Form Numbers**

**2CIBUA09 – Children’s Insurance Rider**

**Regulation 19**

**Arkansas Certification  
Regulation 49**

**We have reviewed Regulation 49 against the issue procedures of the Company and certify that we are in compliance with the requirements of Regulation 49.**

**Aviva Life and Annuity Company**



---

**Chris Guttin, ASA  
Vice-President-Product Operations**

**08/27/2008**

---

**Date**

**Form Numbers**

**Form 2CIBUA09 – Children’s Insurance Rider**

**Regulation 49**



**AmerUs Life Insurance Company**  
 Home Office: Des Moines, IA  
 Mailing Address:  
 P.O. Box 1555  
 Des Moines, IA 50306-1555  
 Fax: 1-800/531-0038



**INDIANAPOLIS LIFE**  
 An AMERUS Company

**Indianapolis Life Insurance Company**  
 Home Office: Indianapolis, IN  
 Mailing Address:  
 P. O. Box 14590  
 Des Moines, IA 50306-3590  
 Fax: 1-888/329-1329

**Application for Insurance**

*Please check appropriate company. ONE BOX MUST BE CHECKED.  
 (In this application, "Company" refers to the insurance company whose name is checked above.)*

**APPLICANT INFORMATION**

**1. PROPOSED INSURED**

Name (First, Middle, Last) \_\_\_\_\_ Is Insured also the Owner?  Yes  No  
 Address \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 City \_\_\_\_\_ Home Ph. (\_\_\_\_) \_\_\_\_\_ Bus. Ph. (\_\_\_\_) \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Gender  M  F Maiden Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Birth State \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Marital Status  Married  Single  Divorced or Separated  Widow or Widower U.S. Citizen?  Yes  No Permanent Resident?  Yes  No  
 Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiry Date \_\_\_\_\_  
 Or, if you do not have a driver's license, other government issued photo ID: Document Type \_\_\_\_\_  
 Document # \_\_\_\_\_ Where Issued \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiry Date \_\_\_\_\_  
 Employer \_\_\_\_\_ How Long? \_\_\_\_\_ Occupation/Duties \_\_\_\_\_  
 Annual earned income \$ \_\_\_\_\_ Annual unearned income \$ \_\_\_\_\_ Net worth \$ \_\_\_\_\_  
 If multiple life product, (2nd app required for multiple life)  
 Joint Insured Names: (1st): \_\_\_\_\_ (2nd): \_\_\_\_\_

**2. OWNER** (If different from Proposed Insured)  Individual  Business  Trust (date of trust) \_\_\_\_\_

Name (Owner, Business or Trustee) \_\_\_\_\_ Birth Date \_\_\_\_\_  
 If trust, name of trust \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Relationship to Proposed Insured \_\_\_\_\_ Social Security # or Taxpayer ID # \_\_\_\_\_  
 Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:  
 Document Type \_\_\_\_\_ Document # \_\_\_\_\_ Where Issued \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiry Date \_\_\_\_\_  
**Contingent Owner** (If none specified, policy provisions will apply.) \_\_\_\_\_  
 Driver's License # or other government issued photo ID document:  
 Document Type \_\_\_\_\_ Document # \_\_\_\_\_ Where Issued \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiry Date \_\_\_\_\_  
 Mail notices to  Insured  Owner  Other (specify) \_\_\_\_\_

Other Notice Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Tax Qualification Type**  Qualified Plan:  Non-Qualified Plan:  Neither  
 Type:  Profit Sharing Plan Type:  Welfare Benefit Plan:  
 401(k)  single employer  
 412(i)  multiple employer  
 Other Defined Benefit  VEBA  
 Deferred Comp  
 Split Dollar  
 Executive Bonus  
 Other \_\_\_\_\_

**3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)**  
 (If necessary, use an additional page for additional details, signature of owner & date.)

Print Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_ Social Security # or Taxpayer ID # \_\_\_\_\_

**4. CONTINGENT BENEFICIARY(IES)**

Print Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_ Social Security # or Taxpayer ID # \_\_\_\_\_



**POLICY INFORMATION**

5. **PRIMARY INSURED**  Nonsmoker/Nontobacco  Smoker/Tobacco  
 Base Plan \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_  
 Additional Coverage \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_  
 Additional Coverage \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_  
**Riders** (Complete Supplemental Application if applicable)  
 Waiver Type \_\_\_\_\_  Other Riders (Type/Amount): \_\_\_\_\_  
 Spouse Rider \$ \_\_\_\_\_  Child Rider \$ \_\_\_\_\_
6. **UL Death Benefit Option:**  Level  Increasing  Death Benefit Return of Premium Rider  
 Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point \_\_\_\_\_% 2 Year Point-to-Point \_\_\_\_\_% 1 Year Monthly Average \_\_\_\_\_%  
 1 Year Monthly Cap \_\_\_\_\_% 1 Year Average Multiple Index \_\_\_\_\_% 5 Year Fixed Term \_\_\_\_\_% 1 Year Fixed Term \_\_\_\_\_% \_\_\_\_\_%  
 Levelized Strategy Transfer  Yes  No
7. **WHOLE LIFE** APL (If applicable)  Yes  No Direct Recognition (if available)  Yes  No

**PREMIUM INFORMATION**

8. **PREMIUM** Planned Premium \$ \_\_\_\_\_ Additional Premium (Lump Sum) \$ \_\_\_\_\_  
 Billing Frequency  Annual  Semi-Annual  Quarterly  PAC (Complete Authorization)  Other \_\_\_\_\_  
 Govt. Allotment (if available)  Group Bill Group Bill # \_\_\_\_\_  
 Has the premium for the policy applied for been given to the agent?  Yes  No Amount \$ \_\_\_\_\_  
 How Paid?  Check  Other (specify) \_\_\_\_\_

**Additional Policy Specifications**

Policy Date (optional) \_\_\_\_\_ Other \_\_\_\_\_

9. **Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy?** .....  Yes  No  
 (If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)
10. **Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else?**  Yes  No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

**NON-MEDICAL INFORMATION**

11. **INSURANCE IN FORCE ON PROPOSED INSURED**  
 a. Are any life insurance or annuity contracts in force? .....  Yes  No  
 If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

- b. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? .....  Yes  No  
 c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company?  Yes  No  
 d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? ..  Yes  No

**12. OTHER NON-MEDICAL INFORMATION**

- a. Do you use any form of tobacco or nicotine based products? .....  Yes  No  
 If no, have you used any form of tobacco or nicotine based products in the last 5 years? .....  Yes  No  
 If yes, when did you last use tobacco or nicotine based products? \_\_\_\_\_ Type \_\_\_\_\_ Quantity \_\_\_\_\_
- b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:  
 1. In any aviation activity other than as a passenger? .....  Yes  No  
 2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? .....  Yes  No
- c. Within the last 5 years, have you filed for bankruptcy (personal or business)? .....  Yes  No  
 d. Within the last 5 years, have you been charged with reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? .....  Yes  No  
 e. Have you been arrested for an illegal activity, acquired a criminal record, or are you currently on probation, parole, or under investigation?  Yes  No  
 f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? .....  Yes  No  
 g. Have you in the past 2 years traveled or do you intend to travel or live outside the United States or Canada? .....  Yes  No  
 h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.?  Yes  No  
 i. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? .....  Yes  No



Give complete details of any **YES** answers to questions 11 and 12. (If necessary, use an additional page for additional details, **signed by the applicant and dated.**) \_\_\_\_\_

**13. PHYSICIAN INFORMATION**

- a. Name, address and phone # of your doctor(s) or health care provider(s): \_\_\_\_\_
- b. When did you last consult a doctor and why? \_\_\_\_\_
- c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) \_\_\_\_\_

**MEDICAL INFORMATION If medical exam is required, questions 14-17 do not need to be completed.**

**14. PROPOSED INSURED**

- a. Height in shoes \_\_\_\_\_ feet \_\_\_\_\_ inches Weight in clothes \_\_\_\_\_ pounds
- b. Have you gained or lost more than 10 pounds in the last year? .....  Yes  No
- c. Are you now under observation or treatment? .....  Yes  No
- d. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ..  Yes  No
- e. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? .....  Yes  No
- f. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? .....  Yes  No

**15. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN TREATED FOR:**

- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ...  Yes  No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? .....  Yes  No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? .....  Yes  No
- d. Diabetes, thyroid, glandular or endocrinal disorder? .....  Yes  No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray?  Yes  No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? .....  Yes  No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ..  Yes  No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? .....  Yes  No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? .....  Yes  No
- j. Anemia, hepatitis, or any blood disorder? .....  Yes  No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? .....  Yes  No

**16. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:**

- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? .....  Yes  No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? .....  Yes  No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? .....  Yes  No
- d. Do you currently use alcoholic beverages? .....  Yes  No  
If yes, what is the average number of drinks per day?  2 or less  3-5  6 or more.

**17. FAMILY HISTORY**

- a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? .....  Yes  No
- b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 14 through 17. (If necessary, use an additional page for additional details, **signed by the applicant & dated.**)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

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 may be guilty of a crime and subject to fines and confinement in prison, depending on state law.



## TAXPAYER IDENTIFICATION

**Instructions** (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner**.

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

**Backup Withholding** - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to the payor; OR
- (2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
- (4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

**Payees Exempt From Backup Withholding** - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

**What Number to Give the Payor** - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

**Obtaining a Number** - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

## AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

## IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**



**AUTHORIZATION AND ACKNOWLEDGMENT**

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

**Personal Health Information**

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

**Personal Private Information**

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

**Limitations, Revocation and Rights**

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

**SIGNATURES**

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at \_\_\_\_\_  
City, State

X \_\_\_\_\_  
Signature of Owner/Proposed Insured  
(or signature of Insured's Personal Representative\*)

On \_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Owner if other than Proposed Insured

X \_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
Parent/Guardian or Witness (if required)

\_\_\_\_\_  
If Owner is a corporation, business firm or trust, give full name and an Authorized person must sign and provide title

\*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

\_\_\_\_\_





**POLICY INFORMATION**

Plan Applied \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_  Nonsmoker/Nontobacco  Smoker/Tobacco  
 UL Death Benefit Option:  Level  Increasing  Death Benefit Return of Premium Rider  
 Additional Coverage \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_  
 Additional Coverage \_\_\_\_\_ Amt. of Ins. \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_  
 Riders \_\_\_\_\_  
 Waiver Type \_\_\_\_\_ Other Riders (Type/Amount) \_\_\_\_\_

**RIDERS (complete supplemental application)**

AIR \$ \_\_\_\_\_ Spouse Rider \$ \_\_\_\_\_ Child Rider \$ \_\_\_\_\_

**PREMIUM INFORMATION**

**Premium Direction / Interest Crediting Strategy:** 1 Year Point-to-Point \_\_\_\_\_% 2 Year Point-to-Point \_\_\_\_\_% 1 Year Monthly Average \_\_\_\_\_%  
 1 Year Monthly Cap \_\_\_\_\_% 1 Year Average Multiple Index \_\_\_\_\_% 5 Year Fixed Term \_\_\_\_\_% 1 Year Fixed Term \_\_\_\_\_% \_\_\_\_\_%  
 Levelized Strategy Transfer  Yes  No  
**Whole Life** APL (if applicable)  Yes  No Direct Recognition (if available)  Yes  No  
**Premium** Planned Premium \$ \_\_\_\_\_ Additional Premium (lump sum) \$ \_\_\_\_\_  
 Billing Frequency  Annual  Semi-Annual  Quarterly  PAC (Complete Authorization)  Other \_\_\_\_\_  
 Govt. Allotment  Group Bill Group Bill # \_\_\_\_\_  
 Has the premium for the policy applied for been given to the agent?  Yes  No Amount \$ \_\_\_\_\_  
 How Paid?  Check  Other (specify) \_\_\_\_\_  
 Policy Date (optional) \_\_\_\_\_ Other \_\_\_\_\_

**Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy?** .....  Yes  No  
 (If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)

**Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else?**  Yes  No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

**INSURANCE IN FORCE ON PROPOSED INSURED**

Are any life insurance or annuity contracts in force? .....  Yes  No  
 If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? .....  Yes  No  
 Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? . . .  Yes  No  
 Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? . . . . .  Yes  No  
 Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? . . . . .  Yes  No  
 Has the proposed insured ever had or been treated by a medical professional for diabetes, heart disease, cancer, alcoholism or drug abuse?  
 .....  Yes  No  
 Give complete details of any **Yes** answers to the questions in this section. (If necessary, use an additional page for additional details,  
**signed by the applicant and dated.**)

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 may be guilty of a crime and subject to fines and confinement in prison, depending on state law.



## TAXPAYER IDENTIFICATION

**Instructions** (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner**.

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

**Backup Withholding** - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to the payor; OR
- (2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
- (4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

**Payees Exempt From Backup Withholding** - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

**What Number to Give the Payor** - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

**Obtaining a Number** - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

## AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

## IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**



**AUTHORIZATION AND ACKNOWLEDGMENT**

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

**Personal Health Information**

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

**Personal Private Information**

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

**Limitations, Revocation and Rights**

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

**SIGNATURES**

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at \_\_\_\_\_  
City, State

X \_\_\_\_\_  
Signature of Owner/Proposed Insured  
(or signature of Insured's Personal Representative\*)

On \_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Owner if other than Proposed Insured

X \_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
Parent/Guardian or Witness (if required)

\_\_\_\_\_  
If Owner is a corporation, business firm or trust, give full name and  
an Authorized person must sign and provide title

\*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

\_\_\_\_\_  
\_\_\_\_\_



**POLICY DATA PAGE (continued)**

POLICY NUMBER: [ALAC1 08]  
INSURED: [JOHN DOE]

<u>BENEFIT</u>	<u>FACE AMOUNT AT ISSUE</u>	<u>EXPIRY DATE</u>
Accelerated Benefit Rider	N/A	Death of Insured
INSURED: Children 15 days to 25 years Children's Insurance Rider	10,000	January 1, 2037