

SERFF Tracking Number: PALD-126137192 State: Arkansas  
Filing Company: Pacific Life Insurance Company State Tracking Number: 42281  
Company Tracking Number: R09ROP  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: R09ROP  
Project Name/Number: R09ROP/R09ROP

## Filing at a Glance

Company: Pacific Life Insurance Company

Product Name: R09ROP

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: PALD-126137192 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 42281

Co Tr Num: R09ROP

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Jill Dease

Disposition Date: 05/11/2009

Date Submitted: 05/05/2009

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: 08/01/2009

State Filing Description:

## General Information

Project Name: R09ROP

Project Number: R09ROP

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/11/2009

Deemer Date:

Submitted By: Jill Dease

Filing Description:

May 8, 2009 NAIC # 00067466

FEIN # 95-1079000

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/11/2009

Created By: Jill Dease

Corresponding Filing Tracking Number:  
R09ROP

Mr. John Shields

Policy Form Filings, Life

Arkansas Department of Insurance

1200 W. Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number: PALD-126137192 State: Arkansas  
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Product Name: R09ROP  
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Re: Form R09ROP, Term Insurance with Limited Return of Premium Rider

Dear Mr. Shields:

We are submitting the above referenced individual (non-group) life insurance form in final print for your approval. This is a primary insured term insurance with limited return of premium rider, and is to be used with the policies identified below, approved on the dates shown below. This filing is being submitted in Nebraska, our state of domicile, and in all other states where Pacific Life is licensed, and where such filing is required.

The following pertain to this submission:

- the rider is to be used with the following approved policies:
  - o Form P08PI3, Flexible Premium Indexed Universal Life, approved 11/13/2007
  - o Form P08PIM, Flexible Premium Indexed Universal Life, approved 11/13/2007
- Issue Ages are 0-70.
- Any required certification forms are included.
- Actuarial Memorandum is included.
- Readability score is 53.6, thus satisfying any readability requirements of your state.
- The forms will be marketed through licensed producers.
- The target release is 8/1/09 or upon approval.
- The forms will be used primarily with application #A09IUW, approved on 8/21/2008.
- If a filing fee is required, it is handled in the usual manner.
- For those states having adopted the NAIC Model Illustration Regulation, please note that this filing is exempt from the requirements of the regulation (Illustrations Actuary's Certification, etc.) since the referenced form is a rider, not a policy.
- The sample rider form displays 2001 CSO rates in all years. The rates for an initial period (generally 5 years) for issued policies will be the rates that are the current rates as of issue.

To the best of my knowledge and belief this filing complies with the laws and regulations of your state. If you would like to discuss any aspect of this filing, please feel free to contact me at (800) 800-7681, extension 7081.

Sincerely,

Jill Dease  
Sr. Compliance Analyst, Product Compliance, Life Division

## Company and Contact

### Filing Contact Information

SERFF Tracking Number: PALD-126137192 State: Arkansas  
 Filing Company: Pacific Life Insurance Company State Tracking Number: 42281  
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Jill Dease, Compliance Analyst Jill.Klinger@pacificlife.com  
 45 Enterprise Drive 949-420-7081 [Phone]  
 Aliso Viejo, CA 92656 949-420-7424 [FAX]

**Filing Company Information**

Pacific Life Insurance Company CoCode: 67466 State of Domicile: Nebraska  
 45 Enterprise Drive Group Code: 709 Company Type:  
 Aliso Viejo, CA 92656 Group Name: State ID Number:  
 (949) 420-7080 ext. [Phone] FEIN Number: 95-1079000

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: \$20.00 per form (when no policy attached)  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pacific Life Insurance Company	\$20.00	05/05/2009	27644068

SERFF Tracking Number: PALD-126137192 State: Arkansas  
Filing Company: Pacific Life Insurance Company State Tracking Number: 42281  
Company Tracking Number: R09ROP  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: R09ROP  
Project Name/Number: R09ROP/R09ROP

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/11/2009	05/11/2009

SERFF Tracking Number: PALD-126137192 State: Arkansas  
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Project Name/Number: R09ROP/R09ROP

## Disposition

Disposition Date: 05/11/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* PALD-126137192      *State:* Arkansas  
*Filing Company:* Pacific Life Insurance Company      *State Tracking Number:* 42281  
*Company Tracking Number:* R09ROP  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* R09ROP  
*Project Name/Number:* R09ROP/R09ROP

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Actuarial Memorandum		No
<b>Form</b>	Term Insurance with Limited Return of Premium Rider		Yes

SERFF Tracking Number: PALD-126137192 State: Arkansas  
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 Product Name: R09ROP  
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## Form Schedule

Lead Form Number: R09ROP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	R09ROP	Application/ Term Enrollment Form	Insurance with Limited Return of Premium Rider	Initial		53.600	R09ROP.pdf

## TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER

This Rider ("Rider") becomes a part of the policy to which it is attached ("the Policy"). All terms of the Policy that do not conflict with this Rider's terms apply to this Rider.

**Rider Benefit Summary** – This Rider provides term insurance on the Insured under the Policy and, during the first five policy years only, the possibility of a Limited Return of Premium Guarantee on surrender of the Policy.

**Term Insurance Benefit** – This Rider provides term insurance on the Insured under the Policy as long as the Policy is In Force and this Rider has not terminated. The Face Amount of this Rider combines with the Face Amount of the Policy to comprise the Total Face Amount, which is used to determine the Death Benefit of the Policy.

**Limited Return of Premium Guarantee** – As long as this guarantee is in force, this rider provides that, on surrender of your Policy during the first five policy years, the Cash Surrender Value will not be less than the Limited Return of Premium Amount.

**Limited Return of Premium Amount** – The Limited Return of Premium Amount is as follows:

- During the first three policy years, the Minimum Return of Premium Amount is 100% of the sum of premiums paid.
- During the fourth policy year, the Minimum Return of Premium Amount is 95% of the sum of premiums paid.
- During the fifth policy year, the Minimum Return of Premium Amount is 90% of the sum of premiums paid.

**Duration of Limited Return of Premium Guarantee** – The Limited Return of Premium Guarantee will generally stay in force for five policy years, and then terminate, However, the Limited Return of Premium Guarantee will terminate earlier if any of the following occur.

- Failure to satisfy the Minimum Premium Requirement for the Limited Return of Premium Guarantee
- A transfer to an Indexed Account with a Segment Term longer than one year
- An increase in Total Face Amount that requires Evidence of Insurability
- A Forced Distribution (see below)
- A Withdrawal or Policy Loan
- Termination of the Rider
- Your Written Request

**Forced Distribution** – A Forced Distribution is a withdrawal or distribution that is required in order to maintain the policy's qualification as a life insurance contract under federal tax law. This can result from certain policy changes including, but not limited to, a reduction in Face Amount. Forced Distributions can begin at the time of the reduction or at a later date, and will continue annually as required (see the policy's provision "Tax Qualification as Life Insurance").

**Minimum Premium Requirement** – To satisfy the Minimum Premium Requirement for the Limited Return of Premium Guarantee ("Minimum Premium Requirement") for the first policy year, you must pay, within 45 days from when we mail the policy for delivery, a premium at least equal to the Annual Premium for the Limited Return of Premium Guarantee, which is shown in the Policy Specifications. To satisfy the Minimum Premium Requirement for the next four policy years you must have paid, no later than the second Monthly Payment Date following each of the first four policy anniversaries, total premiums at least equal to the Annual Premium for the Limited Return of Premium Guarantee multiplied by the number of policy years which have begun.

**Limited Return of Premium Guarantee Grace Period** – If the Minimum Premium Requirement is not paid by the time described in the prior paragraph, we will send you a notice of the amount required to

keep the Limited Return of Premium Guarantee in effect. The notice will show the amount you need to pay to satisfy the Minimum Premium Requirement and the date by which you must pay such amount, which will be the second Monthly Payment Date after the notice. If you do not pay this amount, the Limited Return of Premium Guarantee will terminate with no value.

**Reinstatement** – Upon reinstatement of the Policy, the Limited Return of Premium Guarantee will not be reinstated.

**Insured** – As used in this Rider, the “Insured” means the individual covered under the Policy's Basic Coverage, as shown in the Policy Specifications.

**Rider Coverage Layer** – is a layer of insurance coverage under this Rider. There may be one or more Rider Coverage Layers. Any elective increase in Rider Face Amount will comprise a new Rider Coverage Layer. Each Rider Coverage Layer has its own Face Amount, Risk Class, effective date, and set of charges. The Face Amount, Risk Class, effective date, and set of charges for the initial Rider Coverage Layer are shown in the Policy Specifications. The Face Amount, Risk Class, effective date, and set of charges for any Rider Coverage Layer added at a later time will be shown in a Supplemental Schedule of Coverage sent to you at that time.

**Rider Face Amount** – The Face Amount of this Rider is the sum of the Face Amounts of all Rider Coverage Layers.

**Elective Increases in Rider Face Amount** – Elective increases in the Face Amount of this Rider are increases that you apply for after the Policy has been issued. You may submit an application to increase the Rider Face Amount. Your application must include Evidence of Insurability satisfactory to us and is subject to our approval. The effective date of the increased Rider Face Amount will be the first Monthly Payment Date on or next following the date all required conditions are met or any other date you request and we approve. We reserve the right to limit increases to one per policy year and to charge a fee, not to exceed \$100, to evaluate insurability. Upon approval of any such increase, we will send you a Supplemental Schedule of Coverage, which will include the following information:

- The increased Rider Face Amount and the effective date of the increase
- The Risk Class for the increase
- The Maximum Monthly Cost of Insurance Rates applicable to the increase
- The Maximum Monthly Coverage Charge for the increase
- If the Guideline Premium Test is used, the new Guideline Premiums

**Decrease in Rider Face Amount** – You may decrease the Rider Face Amount, subject to the provisions in the Policy. If there are Coverage Layers with the same effective date, they will be decreased or eliminated in the following order:

- First, the Face Amount of any other Rider that contributes to the Total Face Amount will be decreased or eliminated.
- Then, the Face Amount of this Rider will be decreased or eliminated.
- Finally, the Face Amount of Basic Coverage under the Policy will be decreased.

**Charge for this Rider** – On each Monthly Payment Date prior to the Monthly Deduction End Date, there is a charge for this Rider, which is the sum of

- The Rider Coverage Charge
- The Rider Cost of Insurance Charge
- The Limited Return of Premium Charge

Such charges may vary by Class, and for the purpose of this Rider, Class includes the policy form to which this Rider is attached. The charges described here are maximum charges we guarantee. We may charge less than these maximum charges.

**Rider Coverage Charge** – The Coverage Charge for this Rider is the sum of the Coverage Charge for each Rider Coverage Layer. The Coverage Charge for the initial Rider Coverage Layer will not exceed the Coverage Charge shown in the Policy Specifications. The Coverage Charge for any later Rider Coverage Layer will not exceed the Coverage Charge shown in the Supplemental Schedule of Coverage to be sent to you when the Coverage Layer is added. This charge is based on the Face Amount of the Rider Coverage Layer as of its effective date. The Coverage Charge will not decrease even if the Face Amount of the associated Rider Coverage Layer is decreased.

**Rider Cost of Insurance Charge** – The Cost of Insurance Charge for this Rider is the sum of the Cost of Insurance Charge for each Rider Coverage Layer. The Cost of Insurance Charge for each Rider Coverage Layer will not exceed (1) multiplied by (2), where:

- (1) is the Monthly Cost of Insurance Rate for the Coverage Layer divided by 1000; and  
(2) is the Net Amount at Risk allocated to the Coverage Layer.

The Maximum Monthly Cost of Insurance Rate is shown in the Policy Specifications. The Net Amount at Risk is allocated proportionately to each Coverage Layer, including each Coverage Layer of other Riders that contribute to the Total Face Amount and each Coverage Layer of Basic Coverage under the Policy, according to Face Amount.

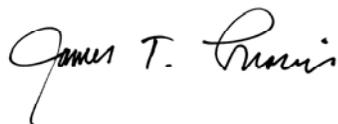
**Limited Return of Premium Charge** – There is a monthly charge for the Limited Return of Premium Guarantee, which will not exceed the charge shown in the Policy Specifications. This charge will terminate when the Limited Return of Premium Guarantee terminates.

**Minimum Death Benefit** – While this Rider is in force, the Minimum Death Benefit of the Policy will be as follows: If the Policy's Death Benefit Qualification Test is the Cash Value Accumulation Test, then the Minimum Death Benefit will be the amount required for this Policy to be deemed a "life insurance" contract according to the Code, but not less than 101% of the greater of the Accumulated Value and the Cash Surrender Value; or if the Policy's Death Benefit Qualification Test is the Guideline Premium Test, then the Minimum Death Benefit will be the death benefit percentage for the Age of the Insured as described in the Policy multiplied by the greater of the Accumulated Value and the Cash Surrender Value.

**Effective Dates** – This Rider is effective on the Policy Date. It will terminate on the earliest of:

- Termination of the Policy
- Your Written Request

Signed for Pacific Life Insurance Company,



Chairman, President, and Chief Executive Officer



Secretary

POLICY SPECIFICATIONS

SUMMARY OF COVERAGES EFFECTIVE ON THE POLICY DATE

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SECTIONS FOR OTHER COVERAGES

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R09ROP	TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER	
	FACE AMOUNT:	\$100,000
	INSURED:	LELAND STANFORD
	SEX AND AGE:	MALE 35
	RISK CLASS:	STANDARD NONSMOKER
	ANNUAL PREMIUM FOR THE LIMITED RETURN OF PREMIUM GUARANTEE:	\$3,015.05
	MONTHLY CHARGE FOR THE LIMITED RETURN OF PREMIUM GUARANTEE	
	POLICY YEARS 1-3:	\$5.03
	POLICY YEAR 4:	\$4.78
	POLICY YEAR 5:	\$4.53

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## POLICY SPECIFICATIONS

TABLE OF COST OF INSURANCE RATES  
FOR TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER

INSURED: LELAND STANFORD

MAXIMUM MONTHLY COST OF INSURANCE RATES PER \$1000.00 OF NET AMOUNT AT RISK  
APPLICABLE TO THIS COVERAGE.

POLICY YEAR	MONTHLY RATE
1	0.10090
2	0.10670
3	0.11170
4	0.12010
5	0.12840
6	0.13760
7	0.14930
8	0.16350
9	0.17930
10	0.19940
11	0.22110
12	0.24200
13	0.26460
14	0.27790
15	0.29380
16	0.31390
17	0.33900
18	0.37330
19	0.41180
20	0.45950
21	0.51560
22	0.57510
23	0.63890
24	0.69180
25	0.75230
26	0.82540
27	0.91630
28	1.02660
29	1.14970
30	1.27900
31	1.41510
32	1.55240
33	1.68980
34	1.83930
35	1.99170
36	2.17330
37	2.37670
38	2.64820
39	2.93180
40	3.23010
41	3.56140
42	3.92360
43	4.34570
44	4.84010

POLICY SPECIFICATIONS

TABLE OF COST OF INSURANCE RATES  
FOR TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER

CONTINUED

INSURED: LELAND STANFORD

MAXIMUM MONTHLY COST OF INSURANCE RATES PER \$1000.00 OF NET AMOUNT AT RISK  
APPLICABLE TO THIS COVERAGE.

POLICY YEAR	MONTHLY RATE
45	5.41330
46	6.04180
47	6.76170
48	7.51460
49	8.33040
50	9.24140
51	10.27540
52	11.43490
53	12.71510
54	14.10520
55	15.59360
56	17.17060
57	18.67330
58	20.26540
59	21.97380
60	23.81220
61	25.79270
62	27.64150
63	29.65380
64	31.85100
65	34.25960
66	36.90860
67	39.06360
68	41.41760
69	43.99540
70	46.82420
71	49.93700
72	53.37330
73	57.18460
74	61.42910
75	66.18210
76	71.53880
77	77.62690
78	83.33330
79	83.33330
80	83.33330
81	83.33330
82	83.33330
83	83.33330
84	83.33330
85	83.33330
86	83.33330
87+	0

POLICY SPECIFICATIONS

TABLE OF MAXIMUM MONTHLY COVERAGE CHARGES  
FOR TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER

INSURED: LELAND STANFORD

POLICY YEAR	COVERAGE CHARGE
1	\$0.00
2	39.60
3	59.40
4	59.40
5	59.40
6	59.40
7	59.40
8	59.40
9	59.40
10	59.40
11	39.60
12	39.60
13	39.60
14	39.60
15	39.60
16	39.60
17	39.60
18	39.60
19	39.60
20	39.60
21	39.60
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31	39.60
32	39.60
33	39.60
34	39.60
35	39.60
36	39.60
37	39.60
38	39.60
39	39.60
40	39.60
41	39.60
42	39.60
43	39.60
44	39.60

POLICY SPECIFICATIONS

TABLE OF MAXIMUM MONTHLY COVERAGE CHARGES  
FOR TERM INSURANCE WITH LIMITED RETURN OF PREMIUM RIDER

CONTINUED

INSURED: LELAND STANFORD

POLICY YEAR	COVERAGE CHARGE
45	\$39.60
46	39.60
47	39.60
48	39.60
49	39.60
50	39.60
51	39.60
52	39.60
53	39.60
54	39.60
55	39.60
56	39.60
57	39.60
58	39.60
59	39.60
60	39.60
61	39.60
62	39.60
63	39.60
64	39.60
65	39.60
66	39.60
67	39.60
68	39.60
69	39.60
70	39.60
71	39.60
72	39.60
73	39.60
74	39.60
75	39.60
76	39.60
77	39.60
78	39.60
79	39.60
80	39.60
81	39.60
82	39.60
83	39.60
84	39.60
85	39.60
86	39.60
87+	0

SERFF Tracking Number: PALD-126137192

State: Arkansas

Filing Company: Pacific Life Insurance Company

State Tracking Number: 42281

Company Tracking Number: R09ROP

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: R09ROP

Project Name/Number: R09ROP/R09ROP

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR1GuarAssocNote.pdf

AR Reg 19 Cert of Compliance.pdf

AR Reg 34 Cert of Compliance.pdf

Readability Certification.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Application

**Comments:**

Approved 8/21/2008

State Tracking # 39971

**Attachment:**

A09IUW.pdf

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

Residents of this state who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association"). The purpose of the 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 Disability 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 Disability Insurance Guaranty Association  
c/o The Liquidation Division  
1200 West Third Street (Third & Cross)  
Little Rock, Arkansas 72201-1904

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 Disability 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 disability 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 \$100,000 in health insurance benefits, \$100,000 in present value of annuity benefits, or \$100,000 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.

**PACIFIC LIFE INSURANCE COMPANY**  
45 Enterprise Drive, Aliso Viejo, CA 92656

**STATE OF ARKANSAS**

**CERTIFICATION OF COMPLIANCE**

**RE:** R09SVERI, R09SVERT, E09DBC

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I hereby certify that to the best of my knowledge and belief, the above forms and their submission comply with Regulation 19, as well as the other laws and regulations of the State of Arkansas.

Signed for the Company at Aliso Viejo, California on December 16, 2008



\_\_\_\_\_  
SIGNATURE

THOMAS S. BEADLESTON

\_\_\_\_\_  
NAME

VICE PRESIDENT

\_\_\_\_\_  
TITLE

**Contact Person:**

Jill Klinger Dease  
Compliance Analyst, Product Compliance, 800-800-7681, extension 7081

(Arkansas)

**PACIFIC LIFE INSURANCE COMPANY**  
45 Enterprise Drive · Aliso Viejo · CA · 92656

**STATE OF ARKANSAS**

**CERTIFICATION OF COMPLIANCE**

**RE:** R09ROP

I hereby certify that to the best of my knowledge and belief, the above forms and their submission comply with Regulation 34.

Signed for the Company at Aliso Viejo, California on April 29, 2009.

Pierre Delisle  
SIGNATURE

Pierre Delisle  
NAME

Assistant Vice President  
TITLE

## READABILITY CERTIFICATION

Form Filing for: **Pacific Life Insurance Company**

Policy Form Number(s): R09ROP

Form Name(s): Term Insurance with Limited Return of Premium Rider

Flesch Score(s): 53.6

(Flesch test was made for entire form, not for selected samples.)

Test type: 10 point

I certify that in my judgment this filing is:

- READABLE (simple sentence structure – shortness of sentences – use of common words – avoidance of legal and technical terms to greatest possible extent and defining of those terms which cannot be avoided – minimum of cross-references).
- LEGIBLE (ample type size for text with contrasting type for headings and subheadings – ample space between lines – ample white space in margins and between section – ample ink-to-paper contrast).
- IN LOGICAL ORDER AND FORMAT (table of contents or index included – sections and subsections self-contained and arranged in logical flow – extensive use of headings and subheadings to facilitate location of particular items – outline form used where desirable for clarity).

I believe this filing:

- Meets or exceeds the requirements of the policy readability legislation already enacted in numerous states; and
- Meets or exceeds the requirements of the NAIC Model Bill on language simplification.

Signed for the Company at Newport Beach, California on

May 1, 2009



\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
THOMAS S. BEADLESTON

NAME

\_\_\_\_\_  
VICE PRESIDENT

TITLE

**PACIFIC LIFE INSURANCE COMPANY**

[Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (949) 462-3066  
www.PacificLife.com]

**PACIFIC LIFE****APPLICATION FOR LIFE INSURANCE****CLIENT INFORMATION**

<b>PROPOSED INSURED</b> Complete for all Life Insurance Policies.	1A. Name: First MI Last		B. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	C. Residence Address: Street City		State Zip Code	
	D. Date of Birth (mm/dd/yyyy)	E. Place of Birth (State/Country)		F. Soc. Sec. #
	G. Driver's License # & State	H. Telephone # (include area code)	I. Occupation	
	J. Proposed Insured is a: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> U.S. Permanent Resident <input type="checkbox"/> Foreign National If Foreign National, provide Country _____ and Visa Type _____			
Employee's work address should be the location where Proposed Insured physically works.	2A. Employer's Name			B. How Long yr mo
	C. Employee's Work Address: Street City			D. Type of Business
<b>PROPOSED ADDITIONAL INSURED</b> Complete for either: • Second-to-Die Life Insurance Policy • Term Rider on Additional Insured (e.g., Spouse) for an Individual Life Insurance Policy Employee's work address should be the location where Proposed Additional Insured physically works.	3A. Name: First MI Last		B. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	C. Residence Address: Street City		State Zip Code	
	D. Date of Birth (mm/dd/yyyy)	E. Place of Birth (State/Country)	F. Soc. Sec. #	G. Relationship to Insured
	H. Driver's License # & State	I. Telephone # (include area code)	J. Occupation	
	K. Proposed Additional Insured is a: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> U.S. Permanent Resident <input type="checkbox"/> Foreign National If Foreign National, provide Country _____ and Visa Type _____			
Employee's work address should be the location where Proposed Additional Insured physically works.	4A. Employer's Name			B. How Long yr mo
	C. Employee's Work Address: Street City			D. Type of Business

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**CLIENT INFORMATION (Continued)**

<b>PRIMARY POLICYOWNER</b> Complete if the policyowner is different than the proposed insured.  If the policyowner is: • A Trust, also complete #7. • A Corporation or business entity, also indicate in #8 the authorized representative's name and title of the person signing as the policyowner on the signature page.	5. Policyowner is (Select one): <input type="checkbox"/> Corporation/Business <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Qualified Plan <input type="checkbox"/> Trust <input type="checkbox"/> Other		
	6A. Name		B. Relationship to Insured(s)
	C. Address: Street		City State Zip Code
	D. Date of Birth (mm/dd/yyyy)	E. Soc. Sec. # / Tax ID #	F. Telephone # (include area code)
	7A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
	C. Additional Trustee's Name		D. Total Number of Trustees
	E. Does your trust agreement require all trustees to sign? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, indicate in Remarks who is required to sign)		
8A. Authorized Representative's Name: First MI Last		B. Title	

<b>ADDITIONAL POLICYOWNER(S)</b> Complete if more than one policyowner.  If the additional policyowner is: • A Trust, also complete # 11. • A Corporation or business entity, also indicate in #12 the authorized representative's name and title of the person signing as the policyowner on the signature page.	9. Policyowner is (Select one): <input type="checkbox"/> Corporation/Business <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Qualified Plan <input type="checkbox"/> Trust <input type="checkbox"/> Other		
	10A. Additional Name		B. Relationship to Insured(s)
	C. Address: Street		City State Zip Code
	D. Date of Birth (mm/dd/yyyy)	E. Soc. Sec. # / Tax ID #	F. Telephone # (include area code)
	11A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
	C. Additional Trustee's Name		D. Total Number of Trustees
	E. Does your trust agreement require all trustees to sign? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, indicate in Remarks who is required to sign)		
12A. Authorized Representative's Name: First MI Last		B. Title	

<b>CERTIFICATION OF POLICYOWNER'S TAXPAYER IDENTIFICATION #</b>	Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined in the instructions in item 3 of the Certification on the official IRS Form W-9).  Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.
	While Pacific Life Insurance Company (Pacific Life) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, Pacific Life does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, Pacific Life's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. Pacific Life does not provide tax or legal advice, and nothing contained herein should be construed as such.

<b>TAX REPORTING ON DISTRIBUTIONS TO FOREIGN NATIONALS</b>	While Pacific Life Insurance Company (Pacific Life) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, Pacific Life does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, Pacific Life's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. Pacific Life does not provide tax or legal advice, and nothing contained herein should be construed as such.
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**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**CLIENT INFORMATION (Continued)**

**PRIMARY BENEFICIARY(IES)**

Total of percentages must equal 100%.

If percentage shares are left blank; the shares will be divided equally.

13A. Name		B. % Share
C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)
14A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
C. Additional Trustee's Name		
15A. Name		B. % Share
C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)
16A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
C. Additional Trustee's Name		
17A. Name		B. % Share
C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)
18A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
C. Additional Trustee's Name		
19A. Name		B. % Share
C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)
20A. Trustee's Name		B. Date of Trust (mm/dd/yyyy)
C. Additional Trustee's Name		

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**CLIENT INFORMATION (Continued)**

<b>PRIMARY CONTINGENT BENEFICIARY(IES)</b> (Optional)  Total of percentages must equal 100%.  If percentage shares are left blank; the shares will be divided equally.	21A. Name			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
	22A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)
	C. Additional Trustee's Name			
	23A. Name			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
24A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)	
C. Additional Trustee's Name				

<b>TERM RIDER ON ADDITIONAL INSURED BENEFICIARY(IES)</b>  Complete if Term Rider on Additional Insured or Second- to-Die Life Insurance Policy's beneficiary is different than the primary beneficiary.  Total of percentages must equal 100%.  If percentage shares are left blank; the shares will be divided equally.	25A. Name			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
	26A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)
	C. Additional Trustee's Name			
	27A. Additional Name (if applicable)			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
28A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)	
C. Additional Trustee's Name				

<b>TERM RIDER ON PRIMARY INSURED BENEFICIARY(IES)</b>  Complete if Second- to-Die Life Insurance Policy's beneficiary is different than the primary beneficiary.  Total of percentages must equal 100%.  If percentage shares are left blank; the shares will be divided equally.	29A. Name			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
	30A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)
	C. Additional Trustee's Name			
	31A. Additional Name (if applicable)			B. % Share
	C. Relationship to Insured(s)	D. Soc. Sec. # / Tax ID #	E. Date of Birth (mm/dd/yyyy)	
32A. Trustee's Name			B. Date of Trust (mm/dd/yyyy)	
C. Additional Trustee's Name				

**REMARKS - IDENTIFY QUESTION AND GIVE DETAILS**

**EXISTING / PENDING INSURANCE INFORMATION**

**IN FORCE, PENDING, AND REPLACEMENT INFORMATION**

1. Is there any existing or pending life insurance or annuities on any Proposed Insured(s)?
  - Yes (Complete any applicable state replacement notice and submit with the application. See IMPORTANT note.)
  - No
2. Will the policy applied for replace, cause a change in, or involve a cash withdrawal or loan from or lapse of any life insurance policy or annuity contract on any Proposed Insured's life?
  - Yes (Complete the applicable state replacement forms and submit with the application. If any are to be processed as a 1035 Exchange or Qualified Transfer of Assets, indicate such in questions 3 and 5 below.)
  - No

**IMPORTANT**

Certain states require replacement forms for any in-force policies even if a replacement is not intended. Refer to Producer Instructions for a list of states.

Add additional policies under Remarks Section.

3. Complete the chart below for all existing life insurance or annuities:

Proposed Insured	Policy/Contract #	Company	Face Amount	Issue Year	CHECK ALL APPLICABLE BOXES								
					Replace	1035 or Transfer Asset	Life	Ann	Ind	Grp	Bus	Pers	
<input type="checkbox"/> Primary <input type="checkbox"/> Additional					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Primary <input type="checkbox"/> Additional					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Primary <input type="checkbox"/> Additional					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Primary <input type="checkbox"/> Additional					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Complete the chart below if you have any applications currently pending or if you plan to apply for any new life insurance or annuity contracts:

Proposed Insured	Policy/Contract #	Company	Face Amount	Reason Policy Applied For
<input type="checkbox"/> Primary <input type="checkbox"/> Additional				
<input type="checkbox"/> Primary <input type="checkbox"/> Additional				
<input type="checkbox"/> Primary <input type="checkbox"/> Additional				

**1035 EXCHANGES OR QUALIFIED TRANSFER OF ASSETS**

5. Complete the following chart if 1035 Exchange or a Qualified Transfer of Assets is checked above. Submit the applicable 1035 Absolute Assignment form or the Transfer of Qualified Plan Assets form:

Policy/Contract #	Loan Carryover		Modified Endowment Contract		
	Yes	No	Yes	No	Unknown
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MODIFIED ENDOWMENT CONTRACT (MEC) DISCLOSURE**

Under federal tax rules, if a policy is received in exchange for an old policy that had become a MEC, the new policy will also be a MEC. This rule applies whether or not the two policies are issued by the same insurance company. A MEC Acceptance Form must be signed and submitted with the application, or must be signed upon policy delivery.

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**PERSONAL INFORMATION**

<b>FINANCIAL INFORMATION</b>		<b>Proposed Insured</b>	<b>Additional Insured</b>
	1. Annual earned income from occupation (After deduction of business expenses)	\$	\$
	2. Annual unearned income (State source in Remarks below)	\$	\$
	3. Net worth: <input type="checkbox"/> Individual <input type="checkbox"/> Joint	\$	\$
	4A. Is the Proposed Insured married? B. If married and applying for individual life insurance, list amount of life insurance in force on the spouse \$ (for business or survivor insurance write N/A)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>GENERAL INFORMATION</b>  Complete each question for the Proposed Insured and Proposed Additional Insured.  Explain all "Yes" answers in Remarks Section unless instructed otherwise.		<b>Proposed Insured</b>	<b>Additional Insured</b>
	5. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember? (If yes, complete the Aviation Questionnaire)	<b>YES</b> <b>NO</b>	<b>YES</b> <b>NO</b>
	6. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing? (If yes, complete the Avocation Questionnaire)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	7. Do you plan or expect to travel or reside outside the USA? (If yes, complete the Travel Questionnaire)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	8. Have you applied for any other life insurance within the last 3 months?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	9. Have you ever had life insurance declined, rated, modified, cancelled, or not renewed?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	10. Have you been convicted of a felony within the past 5 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	11. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	12. Within the last 5 years, have you used or smoked in any quantity tobacco and/or any other product containing nicotine? (If yes, check all that apply and indicate date when product was last used)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

<b>TOBACCO USE INFORMATION</b> Complete if Proposed Insured and/or Proposed Additional Insured is age 20 and above.	<b>PROPOSED INSURED'S INFORMATION</b>		<b>PROPOSED ADDITIONAL INSURED'S INFORMATION</b>	
	<b>Type of Product (check all that apply)</b>	<b>Date last used (mm/yyyy)</b>	<b>Type of Product (check all that apply)</b>	<b>Date last used (mm/yyyy)</b>
	<input type="checkbox"/> Cigarettes		<input type="checkbox"/> Cigarettes	
	<input type="checkbox"/> Cigars		<input type="checkbox"/> Cigars	
	<input type="checkbox"/> Pipe		<input type="checkbox"/> Pipe	
	<input type="checkbox"/> Chewing		<input type="checkbox"/> Chewing	
	<input type="checkbox"/> Patch		<input type="checkbox"/> Patch	
	<input type="checkbox"/> Gum		<input type="checkbox"/> Gum	
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

**MEDICAL CERTIFICATION**

<b>MEDICAL CERTIFICATION</b>  Complete when submitting a medical examination from another insurance company.  Another insurance company's exam may be accepted if the proposed/additional insured was examined within the past six months.	1. The attached examination is on the life of (Use check boxes):		
	<b>Proposed Insured</b>	<b>Additional Insured</b>	<b>Name of Insurance Company</b>
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	2. To the best of your knowledge and belief, are the statements in the examination true as of today? (If no, explain in Remarks)		
	Proposed Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Has the person who was examined consulted a doctor or other medical practitioner, or received medical or surgical advice since the date of the examination? (If yes, explain in Remarks)			
Proposed Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**PREMIUM AND BILLING INFORMATION**

<p><b>AMOUNT PAID WITH THIS APPLICATION</b> The application, TIA, and check should all have the same date.</p>	<p>1A. Is an initial premium submitted with this application?  <input type="checkbox"/> No                      <input type="checkbox"/> Yes (Do not submit money unless the Temporary Insurance Agreement (TIA) is completed)</p> <p>B. If yes, show amount of initial premium. Amount \$ _____                  If yes, by signing in the signature section, I understand, accept, and agree to the terms of the TIA.</p>						
<p><b>PREMIUM FINANCING</b> All questions must be answered.</p>	<p>2. Premium financing, or borrowing life insurance premiums from a lender or other third party, can be a legitimate method of obtaining life insurance premiums. However, not all premium financing arrangements may be appropriate and otherwise in compliance with the applicable laws and regulations. In fact, Pacific Life does not allow its products to be used in certain premium financing arrangements and will decline applications for life insurance made in connection with a premium financing arrangement that is not approved for use with Pacific Life products.</p> <p>A. Have you entered into, or have you made plans to enter into, an agreement to borrow current or future premiums, or both, in connection with this Application for Life Insurance?  <input type="checkbox"/> Yes (Sign the applicable Premium Financing Disclosure Statement and submit with the application)                  Indicate name of the financing agreement _____                  Indicate name of the lender _____  <input type="checkbox"/> No</p> <p>B. Have you made plans to transfer the policy to a third party as repayment of any premium financing debt?  <input type="checkbox"/> Yes (Give details in the Remarks section)    <input type="checkbox"/> No</p>						
<p><b>PREMIUM BILLING METHODS</b> If adding to an existing List Bill, question #4 is not applicable.</p>	<p>3. Billing Method (Check one):                  A. <input type="checkbox"/> Direct                  B. <input type="checkbox"/> Monthly Bank Draft (Complete Authorization for Electronic Funds Transfer (EFT) form)                  C. <input type="checkbox"/> Single Premium                  D. <input type="checkbox"/> List Bill – I/We agree that the premium for this policy shall be included in an itemized list provided to the payor and shall constitute notice of premium due, and I/we understand that I/we will not receive any premium notices or other notices regarding premiums (Check one)  <input type="checkbox"/> New List Bill                      <input type="checkbox"/> Add to Existing List Bill #: _____</p> <p>4. Frequency of Payment for Direct and List Bill: (Check one)                  A. <input type="checkbox"/> Annually    C. <input type="checkbox"/> Quarterly                  B. <input type="checkbox"/> Semi-Annually    D. <input type="checkbox"/> Monthly (Available with List Bill only)</p>						
<p><b>PAYOR OF PREMIUMS</b> Individual or entity paying premium.</p>	<p>5. Payor of premium is: (Check one)    <input type="checkbox"/> Proposed Insured    <input type="checkbox"/> Proposed Additional Insured    <input type="checkbox"/> Primary Policyowner  <input type="checkbox"/> Employer                      <input type="checkbox"/> Other</p> <p>6. Complete information below for above party(ies), if different from (or not included) in Client Information section.</p> <table border="1" data-bbox="305 1203 1554 1371"> <tr> <td data-bbox="305 1203 1222 1255">A. Name</td> <td data-bbox="1222 1203 1554 1255">B. Relationship to Insured(s)</td> </tr> <tr> <td colspan="2" data-bbox="305 1255 1554 1308">C. Care of (if applicable)</td> </tr> <tr> <td data-bbox="305 1308 841 1371">D. Address: Street</td> <td data-bbox="841 1308 1554 1371">City    State                      Zip Code</td> </tr> </table>	A. Name	B. Relationship to Insured(s)	C. Care of (if applicable)		D. Address: Street	City    State                      Zip Code
A. Name	B. Relationship to Insured(s)						
C. Care of (if applicable)							
D. Address: Street	City    State                      Zip Code						
<p><b>ADDITIONAL PREMIUM NOTICES (Optional)</b> Not available for list bill. In addition to the Payor above, the individual or entity entered in this section will receive a premium notice.</p>	<p>7. Send Premium Notices to:    <input type="checkbox"/> Proposed Insured    <input type="checkbox"/> Proposed Additional Insured    <input type="checkbox"/> Primary Policyowner  <input type="checkbox"/> All Policyowners    <input type="checkbox"/> Other</p> <p>8. Complete information below for above party(ies), if different from (or not included) in Client Information section.</p> <table border="1" data-bbox="305 1476 1554 1652"> <tr> <td data-bbox="305 1476 1222 1528">A. Name</td> <td data-bbox="1222 1476 1554 1528">B. Relationship to Insured(s)</td> </tr> <tr> <td colspan="2" data-bbox="305 1528 1554 1581">C. Care of (if applicable)</td> </tr> <tr> <td data-bbox="305 1581 841 1652">D. Address: Street</td> <td data-bbox="841 1581 1554 1652">City    State                      Zip Code</td> </tr> </table>	A. Name	B. Relationship to Insured(s)	C. Care of (if applicable)		D. Address: Street	City    State                      Zip Code
A. Name	B. Relationship to Insured(s)						
C. Care of (if applicable)							
D. Address: Street	City    State                      Zip Code						

**NOTIFICATION INFORMATION**

**ADDITIONAL NOTIFICATIONS**  
(Optional)  
Complete if additional notifications should be sent to another party.

1. Notifications are sent to the primary policyowner and include, but are not limited to, Policy Annual Statements, Last Premium Offers/Lapse Notices, and Confirmation Statements. Indicate where additional notifications should be sent:  
 Proposed Insured     Proposed Additional Insured     Payor     Other

2. Complete information below for above party(ies), if different from (or not included) in Client Information section.

A. Name	B. Relationship to Insured(s)		
C. Care of (if applicable)			
D. Address: Street	City	State	Zip Code

**NOTIFICATIONS FOR EMPLOYER SPONSORED POLICY**  
(Optional)  
Complete if notifications should be sent to a party other than the policyowner.

3. Notifications include, but are not limited to, Policy Annual Statements, Last Premium Offers/Lapse Notices, and Confirmation Statements.

4. Indicate where notifications should be sent:     Employer     Other

5. Complete information below for above party, if different from the policyowner's information.

A. Name			
B. Care of (if applicable)			
C. Address: Street	City	State	Zip Code

**ELECT TO RECEIVE DOCUMENTS IN ELECTRONIC FORMAT**  
(Optional)

6. As the policyowner, by checking YES, I authorize Pacific Life to provide my proxy, prospectuses, fund updates and any other documentation in electronic format when available.  YES

E-mail Address: \_\_\_\_\_ (please print legibly)

By consenting to receive my proxy, prospectuses, fund updates and any other documentation in electronic format, I agree that:

- This election will be effective for all life insurance policies I currently own and for life insurance policies I acquire in the future (may exclude split dollar policies on a list bill)
- Pacific Life will provide my prospectuses and other documents related to my policy electronically instead of sending paper copies of these documents by US mail
- I have the means to view such documents
- I understand that the initial electronic media type for prospectuses will be CD-ROM with future delivery method being an e-mail notification of documents that are viewable online
- Not all Policy documentation and notification may be currently available in electronic format. Any documents added to electronic delivery in the future will also be automatically included in this authorization
- I must have internet access (my internet provider may charge for internet access)
- I must provide a current e-mail address and notify Pacific Life promptly when my e-mail address changes
- I must update any e-mail filters that may prevent me from receiving e-mail notifications from Pacific Life
- I may request a paper copy of the documents at no cost by calling (800) 347-7787
- This authorization will remain in effect until such time as I may decide to revoke this authorization
- I may revoke this authorization at any time by calling (800) 347-7787

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**LIFE INSURANCE COVERAGE INFORMATION**

<b>PRODUCT/PREMIUM</b>	1. Product Name _____	2. Planned Annual Premium \$ _____
<b>FACE AMOUNT/ DEATH BENEFIT</b> Select the appropriate basic and rider/other coverage face amount(s) as shown on the Illustration.  Not all rider/other coverages are available on all products.	3. Basic Coverage Amount \$ _____	Annual Renewable Term \$ _____ Check one term type: <input type="checkbox"/> Level <input type="checkbox"/> Varying Annual Renewable Term (VART) <input type="checkbox"/> Group Term Carve Out (GTCO)
		Annual Renewable Term Rider–Last Survivor \$ _____ Check one term type: <input type="checkbox"/> Level <input type="checkbox"/> Varying Annual Renewable Term (VART)
+		ECV Coverage \$ _____ Surrender Value Enhancement Rider \$ _____ Surrender Value Enhancement Rider–Last Survivor \$ _____ Surrender Value Enhancement Trust/Executive Rider \$ _____ Other \$ _____ Total of Rider/Other Coverage Above \$ _____
		=
		Total Initial Coverage \$ _____
<b>DEATH BENEFIT OPTION</b> Not available on all products.	4. Check one:	<input type="checkbox"/> Option A (Level) <input type="checkbox"/> Option B (Increasing) <input type="checkbox"/> Option C (Face amount plus premiums less distributions)
<b>LIFE INSURANCE QUALIFICATION TEST</b> Both tests not available on all products.	5. Check one: (Qualification test cannot be changed after the policy is in force)	
	A. <input type="checkbox"/> Guideline Premium Test (GPT) B. <input type="checkbox"/> Cash Value Accumulation Test (CVAT)	
<b>GUARANTEED COST OF INSURANCE (COI) PERIOD</b> Not all years available on all products.	6. Indicate number of years:	
	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> Other _____	
<b>OPTIONAL BENEFITS</b> Select the appropriate riders as indicated in the Illustration and indicate face amount(s) where applicable.  Not available on all products.	7. Select the appropriate riders as indicated in the Illustration and indicate face amount(s) where applicable.	
	A. <input type="checkbox"/> Accelerated Living Benefit Rider (Complete disclosure form)                    J. <input type="checkbox"/> Guaranteed Minimum Distribution Rider B. <input type="checkbox"/> Accidental Death Rider \$ _____                    K. <input type="checkbox"/> IRC § 412(e)(3) Life Insurance Rider C. <input type="checkbox"/> Annual Renewable Term Rider <input type="checkbox"/> Varying Individual (Proposed Insured) \$ _____                    L. <input type="checkbox"/> Maturity Extension Rider D. <input type="checkbox"/> Annual Renewable Term Rider <input type="checkbox"/> Varying Individual (Additional Insured) \$ _____                    M. <input type="checkbox"/> Minimum Earnings Benefit Rider _____ years (Indicate a Maturity Period) E. <input type="checkbox"/> Annual Renewable Term Rider Additional Insured \$ _____                    N. <input type="checkbox"/> No Lapse Guarantee Rider F. <input type="checkbox"/> Children’s Term Rider \$ _____                    O. <input type="checkbox"/> Owner Waiver of Charges (Complete Non-Medical form) (Complete Non-Medical form)                    P. <input type="checkbox"/> Payor Waiver of Charges (Complete Non-Medical form) G. <input type="checkbox"/> Disability Benefit Rider \$ _____                    Q. <input type="checkbox"/> Premium Waiver H. <input type="checkbox"/> Flexible Duration No Lapse Guarantee Rider                    R. <input type="checkbox"/> Waiver of Charges (On Insured) I. <input type="checkbox"/> Guaranteed Insurability Rider \$ _____                    S. <input type="checkbox"/> Other _____ T. <input type="checkbox"/> Other _____ U. <input type="checkbox"/> Other _____	
<b>NON-FORFEITURE/ PREMIUM CESSATION OPTIONS</b> (If applicable)	8. <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Insurance <input type="checkbox"/> Reduced Paid-Up	
<b>SPECIAL POLICY DATING</b> Backdating is subject to Pacific Life and state guidelines.	9. A current policy date will be used unless you select one of the following.	
	<input type="checkbox"/> Date to Save Age <input type="checkbox"/> Specific Date _____ (Indicate a date, excluding 29 <sup>th</sup> , 30 <sup>th</sup> , and 31 <sup>st</sup> ) (mm/dd/yyyy) By signing in the signature section, I understand that insurance charges and expenses begin on the policy date.	
<b>MODIFIED ENDOWMENT CONTRACT (MEC) ACCEPTANCE</b> (If applicable)	10. I understand that the policy as applied for is expected to become a Modified Endowment Contract (MEC) prior to its first policy anniversary.	
	<input type="checkbox"/> Yes (I have signed and submitted, or will sign upon policy delivery, a MEC Acceptance Form)	

**ILLUSTRATION INFORMATION**

**ILLUSTRATION ACKNOWLEDGMENT**

**IMPORTANT**

Must complete when applying for a non-variable product.

If box A is checked, a signed illustration must be submitted with the application.

1. An illustration is defined as a presentation or depiction that includes non-guaranteed elements of a policy over a period of years. This includes supplemental illustrations and/or sales material, which can be classified as a supplemental illustration. As applicant, I acknowledge that: (Check one)

A.  An illustration that matches this application was presented, signed, and is being submitted with this application.

B.  An illustration was not presented to me. (Not applicable in Michigan)

C.  An illustration was presented to me; however, the policy applied for is different than as illustrated.

D.  An illustration was displayed to me on a computer screen. The displayed illustration matches the policy applied for; however, no printed copy of the illustration was given to me. The illustration on the screen included personal and policy information as listed in this application.

If B, C, or D is checked, I acknowledge, as applicant, that I did not receive and sign an illustration that matches this application for the reason indicated above. I also understand that an illustration matching the policy as issued will be provided for my signature no later than at the time the policy is delivered.

**ILLUSTRATION DISCLOSURE**

This section applies when applying for a Variable product

I, the applicant, understand that I have applied for and/or purchased a variable universal life insurance policy from Pacific Life. I understand the following about variable universal life insurance and variable universal life insurance illustrations:

- Policy illustrations demonstrate the workings of a policy over time. Policy illustrations are presentations of non-guaranteed policy values over a period of years, based on assumptions of future investment results and assumptions as to what policy charges and credits will then be in effect. The hypothetical investment rates used in illustrations are illustrative only and should not be deemed to represent past or future investment results.
- In addition to investment results, future policy values depend on policy charges and credits. These charges and credits are determined by and may be adjusted by Pacific Life subject to contractual guarantees.
- Future policy values are also dependent on the amount and timing of premium payments, withdrawals and loans. Policy cash values may be more or less than premiums paid.
- The actual performance of the policy is likely to vary from the illustration as actual investment results and future policy charges and credits are either more or less favorable than illustrated. Such changes are likely to change the amount or number of required premiums to meet the original goals.
- The illustration may be based on policy options that require future action. Consult with your representatives to determine which (if any) illustrated policy options require future action.
- Pacific Life does not offer legal advice regarding state and federal tax laws pertaining to life insurance.

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**TELEPHONE & ELECTRONIC AUTHORIZATION INFORMATION**

TELEPHONE &  
ELECTRONIC  
AUTHORIZATION

1. As the Policyowner, I understand that Pacific Life will act upon my telephone and/or electronic instructions for all of the following requests, unless I have chosen to withhold my authorization by checking the box below.

<p><u>Variable Life Policies</u></p> <ul style="list-style-type: none"> <li>• Transfer Between Investment Options</li> <li>• Initiate Dollar Cost Averaging</li> <li>• Rebalance Variable Investment Options</li> <li>• Change Future Premium Allocation Instructions</li> <li>• Initiate Policy Loans</li> </ul>	<p><u>Indexed Universal Life (IUL) Policies</u></p> <ul style="list-style-type: none"> <li>• Automatic Transfers</li> <li>• One-Time Transfers</li> <li>• Recurring Transfers</li> <li>• Initiate Policy Loans</li> </ul>
---	---

Pacific Life will use reasonable procedures to confirm that these requests are authorized and genuine. As long as these procedures are followed, Pacific Life and its affiliates and their directors, trustees, officers, employees, representatives and/or agents, will be held harmless for any claim, liability, loss or cost.

I further understand and agree that telephone and/or electronic transfers and allocation changes will be subject to the policy's terms and conditions and Pacific Life's administrative requirements.

By checking NO, I withhold my authorization for such telephone and/or electronic requests.  NO

AUTHORIZATION FOR  
APPOINTMENT  
(Optional)

2. I authorize and appoint the party(ies) listed below to each act individually on my behalf for the following limited requests, including any telephone and/or electronic requests:

A. Appointee's Name: First                      MI                      Last	Relationship to Policyowner <input type="checkbox"/> Producer <input type="checkbox"/> Other Party
Check one: <input type="checkbox"/> All Requests (listed in Telephone & Electronic Authorization section) <input type="checkbox"/> All Requests (listed in Telephone & Electronic Authorization section) except initiating Policy Loans	
B. Appointee's Name: First                      MI                      Last	Relationship to Policyowner <input type="checkbox"/> Producer <input type="checkbox"/> Other Party
Check one: <input type="checkbox"/> All Requests (listed in Telephone & Electronic Authorization section) <input type="checkbox"/> All Requests (listed in Telephone & Electronic Authorization section) except initiating Policy Loans	

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**INDEXED UNIVERSAL LIFE INSURANCE INFORMATION**

**AUTOMATIC TRANSFERS AFTER PREMIUM PAYMENT AND/OR LOAN REPAYMENT (Required)**  
 Percentages must be whole numbers.  
 A Recurring Transfer is not available if 100% of the Fixed Account is being transferred to one or both of the Indexed Account(s).

1. These are my automatic transfer instructions. The amount\* in the Fixed Account to be transferred to one or both of the Indexed Account(s) selected below on the next transfer date.  
 The sums of the two percentages below do not need to equal 100% and cannot exceed 100%.  
 a. 1 Year Indexed Account \_\_\_\_\_ %  
 b. 5 Year Indexed Account \_\_\_\_\_ %  
 c. By checking NO, I do not elect Automatic Transfers  NO  
 \*The amount automatically transferred is the lesser of: 1) your selected transfer percentage multiplied by all premium and loan repayments paid since the last Transfer Date; and 2) the balance of the Fixed Account as of the applicable Transfer Date.

**SEGMENT MATURITY (Optional)**  
 Percentages must be whole numbers.  
 If not specified, 100% of the value of the matured segment will remain in the Indexed Account(s) and be applied to a new segment of the same duration.

2. These are my segment maturity automatic transfer instructions for the percentage of the Segment Maturity Value to be applied to a new Segment(s) in the Indexed Account(s) or Fixed Account.

A. Transfer From 1 Year Segment Into
_____ % to 1 Year Segment
_____ % to 5 Year Segment
_____ % to Fixed Account
<b>1 Year Segment Maturity MUST TOTAL 100%</b>

B. Transfer From 5 Year Segment Into
_____ % to 1 Year Segment
_____ % to 5 Year Segment
_____ % to Fixed Account
<b>5 Year Segment Maturity MUST TOTAL 100%</b>

**INDEXED UNIVERSAL LIFE INSURANCE INFORMATION (Continued)**

**RECURRING TRANSFER FROM THE FIXED ACCOUNT TO THE INDEXED ACCOUNT (Optional)**

Recurring Transfer available only if Automatic Transfer is less than 100% and not available when premium frequency is monthly.

Percentages must be whole numbers.

3. By completing the section below, I'm requesting to transfer an amount or percentage of the Fixed Account Value to the Indexed Account(s) on each scheduled Transfer Date based on the instructions below.

A. Objective (select one)

1. Deplete\* the value in the Fixed Account over \_\_\_\_\_ months

\*The amount transferred will be a proportionate amount of the Fixed Account Balance based on the number of months indicated. Any balance in the Fixed Account on the date of the last recurring transfer will be transferred to the Indexed Accounts(s).

2. Transfer \$\_\_\_\_\_ or \_\_\_\_\_% of the accumulated value in the Fixed Account for \_\_\_\_\_ months.  
By checking YES, I authorized Pacific Life to deplete any balance in the Fixed Account on the last transfer date.  
 YES

B. Frequency of transfers (select one)

Monthly  Quarterly  Semi-Annually  Annually

C. Transfer the amount derived from A above to the accounts listed below:

\_\_\_\_\_ % to the 1 Year Index Account

\_\_\_\_\_ % to the 5 Year Index Account

**MUST TOTAL 100%**

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**VARIABLE LIFE INSURANCE INFORMATION**

**SELECTION OF PREMIUM ALLOCATION** 1. Indicate how premiums are to be allocated until later changed by you or your authorized representative.  
 A.  Premium Allocation – Complete Premium Allocation section  
 B.  Portfolio Optimization Model – Complete Portfolio Optimization Model section  
 C.  Portfolio Optimization Plus – Complete the Portfolio Optimization Plus section  
 D.  Other Asset Allocation Model \_\_\_\_\_ (Attach additional required forms and indicate any specifics in Remarks)

**PREMIUM ALLOCATION** 2. Indicate percentage amount that you want allocated into each of the investment options below. The total of the percentages must be 100%. Allocation percentages must be whole numbers.

Manager	%	Investment Option	Manager	%	Investment Option
[Alger	_____	Small Cap-Growth	Jennison	_____	Health Sciences
AllianceBernstein	_____	International Value	Lazard	_____	LRS US Strategic
			Lazard	_____	Mid-Cap Equity
Analytics/JPM	_____	Long/Short Large-Cap			
Batterymarch	_____	International Small-Cap	Legg Mason	_____	LMPFA Mid Cap Core II
			Legg Mason	_____	LMPFA Aggressive Growth II
BlackRock	_____	BlackRock Basic Value V.I. III	Loomis Sayles	_____	Large-Cap Growth
BlackRock	_____	BlackRock Global Allocation V.I. III			
BlackRock	_____	Equity Index	MFS	_____	International Large-Cap
BlackRock	_____	Small-Cap Index	MFS	_____	MFS VIT New Discovery SC
			MFS	_____	MFS VIT Utilities SC
Capital Guardian	_____	Diversified Research			
Capital Guardian	_____	Equity	NFJ	_____	Small-Cap Value
Capital Research	_____	American Funds Growth	Oppenheimer	_____	Multi-Strategy
Capital Research	_____	American Funds Growth Income	Oppenheimer	_____	Main Street® Core
			Oppenheimer	_____	Emerging Markets
ClearBridge	_____	Large-Cap Value			
Columbia	_____	Technology	Oppenheimer Capital	_____	Premier VIT OpCap Small Cap
Fidelity®	_____	VIP Contrafund® SC2			
Fidelity®	_____	VIP Freedom 2010 Svc 2	PIMCO	_____	Inflation Managed
Fidelity®	_____	VIP Freedom 2015 Svc 2	PIMCO	_____	Managed Bond]
Fidelity®	_____	VIP Freedom 2020 Svc 2			
Fidelity®	_____	VIP Freedom 2025 Svc 2	Pacific Life	_____	Fixed Account*
Fidelity®	_____	VIP Freedom 2030 Svc 2	Pacific Life	_____	Fixed LT Account*
Fidelity®	_____	VIP Freedom Inc Svc 2			
Fidelity®	_____	VIP Growth SC2	[PAM	_____	Money Market
Fidelity®	_____	VIP Mid-Cap SC2	PAM	_____	High Yield Bond
Fidelity®	_____	VIP Value Strategies SC2			
			T. Rowe Price	_____	T. Rowe Price Blue Chip Growth II
			T. Rowe Price	_____	T. Rowe Price Equity Income II
Goldman Sachs	_____	Short Duration Bond			
			Van Eck	_____	Van Eck Worldwide Hard Assets
Highland Capital	_____	Floating Rate Loan Portfolio			
			Van Kampen	_____	Comstock
J. P. Morgan	_____	Diversified Bond	Van Kampen	_____	Real Estate
			Van Kampen	_____	Mid-Cap Growth
Janus	_____	Growth LT			
Janus	_____	Focused 30	Vaughan Nelson	_____	Small-Cap Equity]
Janus	_____	JAS Int'l Growth SC			
Janus	_____	JAS Mid-Cap Growth SC			
Janus	_____	JAS Risk Managed Core SC			

**Other Investment Options**

Manager	%	Investment Option

**MUST TOTAL 100%**

\*The Fixed LT Account has less transfer liquidity and may credit a higher current rate of interest than the Fixed Account. Both fixed account options credit a fixed minimum guaranteed interest rate. The Fixed Accounts are not available for automatic rebalancing. See the prospectus for details.

**VARIABLE LIFE INSURANCE INFORMATION (Continued)**

PORTFOLIO  
OPTIMIZATION  
MODEL  
(Optional)

3. Subject to the Free-Look Transfer Date; I, as applicant, direct that my initial premium, less any premium loads, be allocated based on the Portfolio Optimization model that I selected below. I also direct all future premiums, less premium loads, be allocated to this model, unless otherwise instructed by me in writing.

**Target Composition [(as of 5/2/08)]**

Underlying Portfolios	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>	E <input type="checkbox"/>
[Small-Cap Growth	-	-	2%	2%	3%
International Value	3%	5%	6%	9%	10%
Long/Short Large-Cap	1%	2%	2%	3%	4%
International Small-Cap	-	1%	2%	3%	3%
Equity Index	2%	3%	3%	4%	4%
Small-Cap Index	-	-	-	-	2%
Diversified Research	1%	2%	2%	2%	2%
American Funds Growth-Income	-	-	3%	5%	5%
American Funds Growth	-	4%	4%	4%	5%
Large-Cap Value	4%	5%	6%	6%	7%
Short Duration Bond	12%	9%	4%	2%	-
Floating Rate Loan	8%	5%	3%	-	-
Focused 30	-	-	1%	1%	2%
Growth LT	-	2%	3%	3%	4%
Diversified Bond	15%	10%	6%	2%	-
Mid-Cap Equity	3%	6%	8%	10%	11%
Large-Cap Growth	-	-	2%	2%	2%
International Large-Cap	3%	4%	4%	8%	9%
Small-Cap Value	-	1%	1%	1%	1%
Main Street Core	3%	4%	4%	4%	5%
Emerging Markets	-	-	3%	4%	5%
High Yield Bond	4%	3%	2%	-	-
Managed Bond	21%	16%	11%	4%	-
Inflation Managed	18%	14%	11%	8%	-
Mid-Cap Growth	-	1%	2%	2%	2%
Comstock	2%	3%	4%	6%	6%
Real Estate	-	-	-	2%	4%
Small-Cap Equity	-	-	1%	3%	4%]

PORTFOLIO  
OPTIMIZATION PLUS  
(Optional)

Indicate the desired Fund Manager and Investment Option from the list of approved funds shown in the Premium Allocation Section on the previous page.

Allocation percentages must be whole numbers.

4A. I direct the percentages listed below to be allocated into each of the investment options outside of the Portfolio Optimization model. I understand that the investment options I listed below must not be investment options currently within the Portfolio Optimization model.

The percentage(s) I have listed below must total less than 100%.

Manager	%	Investment Option

B. Indicate which Portfolio Optimization model (see model composition above) the remaining percentage should be allocated to:

A                       B                       C                       D                       E

**VARIABLE LIFE INSURANCE INFORMATION (Continued)**

**PORTFOLIO OPTIMIZATION  
ACKNOWLEDGMENT**

5. With respect to enrolling in the Portfolio Optimization Service, by signing this application I understand that:
- I am directing my initial net premium payment be allocated based on the Portfolio Optimization model that I selected in the previous section. I also direct that subsequent net premium payments be allocated according to this model, as it may be modified from time to time, unless I instruct otherwise in writing.
  - I may utilize investment tools made available by Pacific Life Fund Advisors LLC (PLFA) for selecting a Portfolio Optimization model, but I understand that it is my decision, in consultation with my financial professional, to select a model. Neither PLFA nor Pacific Life bear responsibility for my decision.
  - The risk tolerance and models shown are targets only and that participation in Portfolio Optimization is not a guarantee against market loss.
  - Portfolio Optimization models will be analyzed from time to time and as a result, the investment options may be added or deleted from a model and/or the weightings of the investment options within a model may change. These investment options may be different from those currently available (including investment options not currently available). I have read the prospectus and the ADV brochure and understand that my model may be automatically updated. I grant PLFA, as investment adviser, limited discretionary investment authority to periodically make changes in the Portfolio Optimization investment options and to allocate and reallocate my account value in accordance with the Portfolio Optimization model I have selected, since the Portfolio Optimization model will be updated from time to time. PLFA can only transfer such discretionary authority (for example, the ability to periodically change model allocations) to another party with my consent, although PLFA may assume consent if it provides advance notice and I do not object. (For purposes of the preceding sentence, "transfer" means "assign" as interpreted under the Investment Advisers Act of 1940.)
  - I will receive transaction confirmations of the annual automatic updates, if applicable.
  - I will notify my financial professional if my financial situation and risk profile change in order to determine if I need to change to a different Portfolio Optimization model. I understand that I should periodically review, in consultation with my financial professional, my financial situation and risk profile to determine if I need to change my selected model.
  - Terminating my participation in the Portfolio Optimization service or participating in the Portfolio Optimization Plus service may impact my eligibility benefits under certain Pacific Life riders.
  - The Portfolio Optimization Service may be terminated at any time. PLFA and Pacific Life have no contractual obligation to continue the program.

**IMPORTANT**

Applicant's initials required if Portfolio Optimization or Portfolio Optimization Plus was selected.

Initials

**I have received Pacific Life Fund Advisors' Form ADV brochure.**

**ACKNOWLEDGMENT**

- With respect to the purchase of this variable life insurance policy, by signing this application I, acknowledge that:
- I understand that the amount and duration of the death benefit may vary, depending on the investment performance of the variable investment options.
  - I understand that the policy values may increase or decrease, depending on the investment experience of the variable investment options.
  - I have considered the liquidity needs, risk tolerance and investment time horizon in selecting the variable investment options.
  - My registered representative provided me with a copy of the prospectus(es) for the variable life insurance policy I applied for, as well as prospectuses for all variable insurance funds which are available within the policy.
- POLICY VALUES MAY INCREASE OR DECREASE, AND MAY EVEN BE REDUCED TO ZERO AND CAUSE THE POLICY TO LAPSE WITHOUT VALUE, DEPENDING ON THE EXPERIENCE OF THE VARIABLE INVESTMENT OPTIONS. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS. A CURRENT ILLUSTRATION OF BENEFITS, INCLUDING DEATH BENEFITS AND HYPOTHETICAL CASH SURRENDER VALUES, IS AVAILABLE UPON REQUEST.**



**ADDITIONAL LIFE INSURANCE COVERAGE INFORMATION**

**ADDITIONAL INSURANCE**  
(Optional)

Complete and submit the appropriate product pages when applying for both a variable and non-variable product.

A separate application should be completed in place of completing this section if any of the following apply:

- different policyowners
- different applicants
- premium allocations for variable products will be different
- percentage amounts for Indexed Universal Life products will be different.

	1. Product Name	2. Planned Annual Premium \$																																		
3. Basic Coverage Amount \$ _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Annual Renewable Term</td> <td style="width: 50%; text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2">Check one term type:</td> </tr> <tr> <td><input type="checkbox"/> Level</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Varying Annual Renewable Term (VART)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Group Term Carve Out (GTCO)</td> <td></td> </tr> <tr> <td>Annual Renewable Term Rider—Last Survivor</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2">Check one term type:</td> </tr> <tr> <td><input type="checkbox"/> Level</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Varying Annual Renewable Term (VART)</td> <td></td> </tr> <tr> <td>ECV Coverage</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Rider</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Rider—Last Survivor</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Trust/Executive Rider</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Other _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2" style="text-align: right;"><b>Total of Rider/Other Coverage Above</b></td> </tr> <tr> <td style="text-align: right;">+</td> <td></td> <td style="text-align: right;">=</td> <td>Total Initial Coverage \$ _____</td> </tr> </table>	Annual Renewable Term	\$ _____	Check one term type:		<input type="checkbox"/> Level		<input type="checkbox"/> Varying Annual Renewable Term (VART)		<input type="checkbox"/> Group Term Carve Out (GTCO)		Annual Renewable Term Rider—Last Survivor	\$ _____	Check one term type:		<input type="checkbox"/> Level		<input type="checkbox"/> Varying Annual Renewable Term (VART)		ECV Coverage	\$ _____	Surrender Value Enhancement Rider	\$ _____	Surrender Value Enhancement Rider—Last Survivor	\$ _____	Surrender Value Enhancement Trust/Executive Rider	\$ _____	Other _____	\$ _____	<b>Total of Rider/Other Coverage Above</b>		+		=	Total Initial Coverage \$ _____	
Annual Renewable Term	\$ _____																																			
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Surrender Value Enhancement Trust/Executive Rider	\$ _____																																			
Other _____	\$ _____																																			
<b>Total of Rider/Other Coverage Above</b>																																				
+		=	Total Initial Coverage \$ _____																																	

4. Check one:  Option A (Level)     Option B (Increasing)     Option C (Face amount plus premiums less distributions)

5. Check one: (Qualification test cannot be changed after the policy is in force)

A.  Guideline Premium Test (GPT)

B.  Cash Value Accumulation Test (CVAT)

6. Indicate number of years:

0     1     2     3     5     10     15     Other \_\_\_\_\_

7. Select the appropriate riders as indicated in the Illustration and indicate face amount(s) where applicable.

<p>A. <input type="checkbox"/> Accelerated Living Benefit Rider (Complete disclosure form)</p> <p>B. <input type="checkbox"/> Accidental Death Rider \$ _____</p> <p>C. <input type="checkbox"/> Annual Renewable Term Rider    <input type="checkbox"/> Varying Individual (Proposed Insured) \$ _____</p> <p>D. <input type="checkbox"/> Annual Renewable Term Rider    <input type="checkbox"/> Varying Individual (Additional Insured) \$ _____</p> <p>E. <input type="checkbox"/> Annual Renewable Term Rider Additional Insured \$ _____</p> <p>F. <input type="checkbox"/> Children's Term Rider \$ _____ (Complete Non-Medical form)</p> <p>G. <input type="checkbox"/> Disability Benefit Rider \$ _____</p> <p>H. <input type="checkbox"/> Flexible Duration No Lapse Guarantee Rider</p> <p>I. <input type="checkbox"/> Guaranteed Insurability Rider \$ _____</p>	<p>J. <input type="checkbox"/> Guaranteed Minimum Distribution Rider</p> <p>K. <input type="checkbox"/> IRC § 412(e)(3) Life Insurance Rider</p> <p>L. <input type="checkbox"/> Maturity Extension Rider</p> <p>M. <input type="checkbox"/> Minimum Earnings Benefit Rider _____ years (Indicate a Maturity Period)</p> <p>N. <input type="checkbox"/> No Lapse Guarantee Rider</p> <p>O. <input type="checkbox"/> Owner Waiver of Charges (Complete Non-Medical form)</p> <p>P. <input type="checkbox"/> Payor Waiver of Charges (Complete Non-Medical form)</p> <p>Q. <input type="checkbox"/> Premium Waiver</p> <p>R. <input type="checkbox"/> Waiver of Charges (On Insured)</p> <p>S. <input type="checkbox"/> Other _____</p> <p>T. <input type="checkbox"/> Other _____</p> <p>U. <input type="checkbox"/> Other _____</p>
---	--

8.  Automatic Premium Loan     Extended Insurance     Reduced Paid-Up

9. A current policy date will be used unless you select one of the following.

Date to Save Age     Specific Date \_\_\_\_\_ (Indicate a date, excluding 29<sup>th</sup>, 30<sup>th</sup>, and 31<sup>st</sup>)  
(mm/dd/yyyy)

By signing in the signature section, I understand that insurance charges and expenses begin on the policy date.

10. I understand that the policy as applied for is expected to become a Modified Endowment Contract (MEC) prior to its first policy anniversary.

Yes (I have signed and submitted, or will sign upon policy delivery, a MEC Acceptance Form)

**ALL COMPLETED FIELDS OF THE PRIMARY APPLICATION NOT INCLUDED IN THIS SECTION WILL APPLY UNLESS CHANGES ARE SPECIFIED IN REMARKS.**

**ALTERNATE LIFE INSURANCE COVERAGE INFORMATION**

**ALTERNATE INSURANCE (Optional)**

Complete and submit the appropriate product pages when applying for both a variable and non-variable product.

A separate application should be completed in place of completing this section if any of the following apply:

- different policyowners
- different applicants
- premium allocations for variable products will be different
- percentage amounts for Indexed Universal Life products will be different.

	1. Product Name	2. Planned Annual Premium \$																																
3. Basic Coverage Amount \$ _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Annual Renewable Term</td> <td style="width: 50%; text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2">Check one term type:</td> </tr> <tr> <td><input type="checkbox"/> Level</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Varying Annual Renewable Term (VART)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Group Term Carve Out (GTCO)</td> <td></td> </tr> <tr> <td>Annual Renewable Term Rider—Last Survivor</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2">Check one term type:</td> </tr> <tr> <td><input type="checkbox"/> Level</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Varying Annual Renewable Term (VART)</td> <td></td> </tr> <tr> <td>ECV Coverage</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Rider</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Rider—Last Survivor</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Surrender Value Enhancement Trust/Executive Rider</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>Other _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td colspan="2" style="text-align: right;"><b>Total of Rider/Other Coverage Above</b></td> </tr> <tr> <td colspan="2" style="text-align: right;">\$ _____</td> </tr> </table>	Annual Renewable Term	\$ _____	Check one term type:		<input type="checkbox"/> Level		<input type="checkbox"/> Varying Annual Renewable Term (VART)		<input type="checkbox"/> Group Term Carve Out (GTCO)		Annual Renewable Term Rider—Last Survivor	\$ _____	Check one term type:		<input type="checkbox"/> Level		<input type="checkbox"/> Varying Annual Renewable Term (VART)		ECV Coverage	\$ _____	Surrender Value Enhancement Rider	\$ _____	Surrender Value Enhancement Rider—Last Survivor	\$ _____	Surrender Value Enhancement Trust/Executive Rider	\$ _____	Other _____	\$ _____	<b>Total of Rider/Other Coverage Above</b>		\$ _____		Total Initial Coverage \$ _____
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<b>Total of Rider/Other Coverage Above</b>																																		
\$ _____																																		

4. Check one:  Option A (Level)     Option B (Increasing)     Option C (Face amount plus premiums less distributions)

5. Check one: (Qualification test cannot be changed after the policy is in force)

A.  Guideline Premium Test (GPT)

B.  Cash Value Accumulation Test (CVAT)

6. Indicate number of years:

0     1     2     3     5     10     15     Other \_\_\_\_\_

7. Select the appropriate riders as indicated in the Illustration and indicate face amount(s) where applicable.

A. <input type="checkbox"/> Accelerated Living Benefit Rider (Complete disclosure form) B. <input type="checkbox"/> Accidental Death Rider \$ _____ C. <input type="checkbox"/> Annual Renewable Term Rider <input type="checkbox"/> Varying Individual (Proposed Insured) \$ _____ D. <input type="checkbox"/> Annual Renewable Term Rider <input type="checkbox"/> Varying Individual (Additional Insured) \$ _____ E. <input type="checkbox"/> Annual Renewable Term Rider Additional Insured \$ _____ F. <input type="checkbox"/> Children's Term Rider \$ _____ (Complete Non-Medical form) G. <input type="checkbox"/> Disability Benefit Rider \$ _____ H. <input type="checkbox"/> Flexible Duration No Lapse Guarantee Rider I. <input type="checkbox"/> Guaranteed Insurability Rider \$ _____	J. <input type="checkbox"/> Guaranteed Minimum Distribution Rider K. <input type="checkbox"/> IRC § 412(e)(3) Life Insurance Rider L. <input type="checkbox"/> Maturity Extension Rider M. <input type="checkbox"/> Minimum Earnings Benefit Rider _____ years (Indicate a Maturity Period) N. <input type="checkbox"/> No Lapse Guarantee Rider O. <input type="checkbox"/> Owner Waiver of Charges (Complete Non-Medical form) P. <input type="checkbox"/> Payor Waiver of Charges (Complete Non-Medical form) Q. <input type="checkbox"/> Premium Waiver R. <input type="checkbox"/> Waiver of Charges (On Insured) S. <input type="checkbox"/> Other _____ T. <input type="checkbox"/> Other _____ U. <input type="checkbox"/> Other _____
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**ALL COMPLETED FIELDS OF THE PRIMARY APPLICATION NOT INCLUDED IN THIS SECTION WILL APPLY UNLESS CHANGES ARE SPECIFIED IN REMARKS.**

**APPLICANT/POLICYOWNER'S REPRESENTATION OF INSURABLE INTEREST**

**REPRESENTATION OF INSURABLE INTEREST** As the Applicant and/or Policyowner, I represent that the Policyowner and Beneficiary have an insurable interest in the life of the Proposed Insured(s). (Applicable except where the Proposed Insured is both Applicant and Policyowner.)

**PROPOSED INSURED'S CONSENT FOR EMPLOYER OWNED INSURANCE**

**PROPOSED INSURED'S CONSENT** As the proposed insured, I acknowledge and understand that (i) my employer (the "Employer"), or a trust established by my employer (the "Trust"), is involved in this Application for life insurance insuring my life ("Life Insurance Coverage"), (ii) the Employer or the Trust will have an interest as policyowner and/or beneficiary of the Life Insurance Coverage as reflected in this Application, and (iii) both I and my heirs may have no right or interest in or to the Life Insurance Coverage and its proceeds.

Applicable only if the employer or an employer-controlled trust is to be the policyowner of this policy.

I (i) consent to the issuance of the Life Insurance Coverage as requested in this Application; (ii) acknowledge that the Life Insurance Coverage may continue after the termination of my employment with the Employer; (iii) acknowledge that my Employer has notified me in writing of the maximum life insurance face amount for which my Employer may seek Life Insurance Coverage insuring my life; and (iv) acknowledge that Pacific Life will not necessarily issue a policy at this maximum life insurance face amount.

My consent to this insurance has not been obtained by coercion of my Employer or its representatives or agents, whether express or implied. By my signature in the Signatures section, I am consenting to the Employer's and/or Trust's future purchase of additional Life Insurance Coverage up to the maximum amount described above, for which no additional notice to, or consent from me will be necessary.

**EMPLOYER ACKNOWLEDGMENT**

**EMPLOYER ACKNOWLEDGMENT REGARDING THE POTENTIAL TAXATION OF DEATH BENEFITS** I acknowledge and understand: (i) the potential significance of IRC section 101(j); and (ii) that, if IRC section 101(j) applies, the policy(s) death benefit may be income taxable unless I, as employer, have satisfied the conditions of IRC Section 101(j); and (iii) that Pacific Life and its producers are not authorized to provide tax or legal advice and that I must look to my independent tax and legal advisors for current information regarding this and other laws that may impact me and my life insurance policies.

I understand that it remains the employer's responsibility to ensure both current and ongoing compliance with the requirements of IRC sections 101(j) and 6039I.

By signing in the Signatures section, I acknowledge my understanding of this information, and that I have obtained or will obtain from my independent tax and legal advisors whatever advice I deem necessary or appropriate concerning the taxation of my life insurance policies.

**APPLICATION PACKAGE**

**PAGES NOT SUBMITTED** 1. Indicate below each page not submitted from this application (Check all that apply):

Complete this section if one of the pages indicated in this section is blank and will not be submitted to the Life Insurance Operations Center.

A.  Pages 12-13 – Indexed Universal Life Insurance Information

B.  Pages 14-17 – Variable Life Insurance Information

C.  Page 18 – Additional Life Insurance Coverage Information

D.  Page 19 – Alternate Life Insurance Coverage Information

Note: Only the above-referenced pages are not required to be submitted if blank. The omission of any other pages may result in rejection of the application.

**NEW BUSINESS DATE STAMP (For Internal Use Only)****DECLARATIONS**

The answers provided in this application are true and complete to the best of my knowledge and belief. I understand and agree that:

1. (NOT APPLICABLE IN WEST VIRGINIA) Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by Pacific Life as indicated under the title "Endorsement," where permitted by state law. All other changes made to the application or policy by Pacific Life will be indicated on an "Application Amendment Form" that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. (APPLICABLE ONLY IF THE EMPLOYER OR AN EMPLOYER-CONTROLLED TRUST IS TO BE THE OWNER OF THIS POLICY) If insurance is being applied for on the life of any non-exempt employee, then such insurance is not prohibited by applicable state law.
3. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the producer, whose name appears below, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.

**DECLARATIONS (Continued)**

4. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire first premium is paid only if at that time the Proposed Insured(s) is alive, and all answers in this application that are material to the risk are still true and complete.
5. If I have given money with the application and received a TIA and if the coverage amount of the application exceeds the TIA coverage limits, I understand that if the Proposed Insured(s) die(s) before a policy is delivered, the death benefit will be limited to the TIA coverage limit.
6. I must inform the Producer or Pacific Life Insurance Company (PL) in writing of any changes in the health of any Proposed Insured(s) or if any of the statements or answers on this application change prior to delivery of the policy.
7. My statements and answers in this application must continue to be true as of the date I receive the policy.
8. No Producer is authorized to make or change contracts or insurance policies on the behalf of Pacific Life and no Producer may alter the terms of this application, the TIA, or the policy, nor does the Producer have the authority to waive any of Pacific Life's rights or requirements.
9. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the producer or the Company about the specific premium and risk class referenced in my policy.
10. The policy(ies) as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
11. If this application is for flexible premium universal life insurance with equity indexed feature, I ACKNOWLEDGE that: I am applying for an indexed product, for which the annual crediting for the indexed account tracks the gains and the losses of an outside financial index, subject to a growth cap and floor. I further understand that, while the values of the policy may be determined in part, by reference to an external index, the policy does not directly participate in any stock or equity investments and values shown to me, other than the minimum values, are not guarantees, promises, or warranties.

**SIGNATURES**

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 and subjects such person to criminal and civil penalties. (Not applicable in Oregon.)

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the representations herein. If the entity is a corporation, you further represent that all requirements under applicable law and under the corporation's governing documents have been satisfied concerning the execution of this document, including the use of the corporate seal and number of signing officers.

If insured or owner is under age 16, a signature of parent/guardian is required in place of the minor's signature.

SIGNED BY APPLICANT IN:

City	State
------	-------

APPLICANT SIGNED AND DATED ON:

Date (mm/dd/yyyy)
-------------------

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

SIGN HERE

X \_\_\_\_\_

\*Applicant's Signature, always required & Title, if corporation, trust or business entity

THE APPLICANT IS THE PARTY THAT APPLIES FOR THE POLICY.

Applicant's Name: First MI Last (print)	Relationship To Proposed Insured
---	----------------------------------

SIGN HERE

X \_\_\_\_\_

Proposed Insured's Signature, if other than applicant

SIGN HERE

X \_\_\_\_\_

Proposed Additional Insured's Signature, if applicable

SIGN HERE

X \_\_\_\_\_

\*Policyowner's Signature, if other than applicant or insured & Title, if corporation, trust, or business entity

SIGN HERE

X \_\_\_\_\_

\*Additional Policyowner's Signature & Title, if applicable

\*If a corporation or business entity, indicate name below. The signature and title of any authorized representative is required and should be shown in the Client Information section. If a trust, all required trustees must sign according to the trust agreement.

Corporation or Business Entity's Name, if applicable
--

**PRODUCER'S CERTIFICATION**

I certify that I have truly and accurately recorded the information supplied in the application.

SIGN HERE

X \_\_\_\_\_

Soliciting Producer's Signature

Soliciting Producer's Name: First MI Last (print)
---

**PACIFIC LIFE INSURANCE COMPANY**

[Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (949) 462-3066  
www.PacificLife.com]

**AUTHORIZATION TO OBTAIN INFORMATION**

This authorization complies with HIPAA Privacy Rules

**PROPOSED INSURED'S INFORMATION**

<b>Proposed Insured's Name: First</b>	<b>MI</b>	<b>Last</b>	<b>Date of Birth (mm/dd/yyyy)</b>	<b>Place of Birth (state/country)</b>
<b>Proposed Additional Insured's Name: First</b>	<b>MI</b>	<b>Last (if applicable)</b>	<b>Date of Birth (mm/dd/yyyy)</b>	<b>Place of Birth (state/country)</b>

I authorize any physician, health care professional, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, medical facility, other medical or medically related facility, insurance company, health plan, the Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle agency, or employer to release to Pacific Life Insurance Company ("PL") its subsidiaries, reinsurers, employees and representatives, any information they may have in their possession or under their control as to the diagnosis, treatment, prognosis of any physical or mental condition, human immunodeficiency virus (HIV) infection, sexually transmitted diseases, treatment of mental illness, and the use of tobacco, and any non-medical information, including finances, avocations, occupation, foreign travel, and driving record for me and any minor children who are to be insured. Although Federal Regulation protects information related to drug or alcohol abuse from disclosure, I give permission to collect this information. This authorization is not affected or limited by any prior agreements I may have made with any of the above persons or entities to restrict the release of such information, and I instruct them to release and disclose all such information without restriction.

I understand that the reason for releasing such information under this authorization is to determine eligibility for insurance and that such information will not be released to any person or organization except a reinsurer, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with my application, or as may be otherwise required by law, or as I may further authorize. I understand that I may revoke this authorization at any time by sending a written revocation request to Pacific Life Insurance Company at: [P. O. Box 2030, Omaha, NE 68103-2030]. Such a revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right Pacific Life has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke this authorization, Pacific Life may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

This authorization shall remain in force for 24 months after the date of my signature below, and a copy of this authorization is as valid as the original. I understand that once any such health-related information is released pursuant to this authorization, that information may be redisclosed and will no longer be covered or protected by the HIPAA rules governing privacy and confidentiality of health information.

I acknowledge that I have received the disclosure notice and a copy of this authorization.

**SIGNATURES**

Signed and Dated by the Insured(s) in: \_\_\_\_\_  
City
State
Date (mm/dd/yyyy)



X

\_\_\_\_\_  
**Proposed Insured's Signature** (or parent/guardian if under age 16)



X

\_\_\_\_\_  
**Proposed Additional Insured's Signature** (or parent/guardian if under age 16)

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**PACIFIC LIFE INSURANCE COMPANY**

[Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (949) 462-3066  
www.PacificLife.com]



**PACIFIC LIFE**

**PRODUCER REPORT**

<b>Proposed Insured's Name:</b> First	MI	Last	<b>Date of Birth</b> (mm/dd/yyyy)
<b>Proposed Additional Insured's Name:</b> First	MI	Last (if applicable)	<b>Date of Birth</b> (mm/dd/yyyy)

**BUSINESS INSURANCE INFORMATION**

<p><b>BUSINESS INSURANCE</b> Complete if applying for business insurance.</p>	<p>1. This life insurance policy is being purchased in conjunction with a:</p> <table style="width:100%;"> <tr> <td>A. <input type="checkbox"/> Buy/Sell</td> <td>E. <input type="checkbox"/> Employee Benefit</td> <td>H. <input type="checkbox"/> Section 79 (10+ Plan Participants)</td> </tr> <tr> <td>B. <input type="checkbox"/> Controlled Executive Bonus Plan</td> <td>F. <input type="checkbox"/> Key Employee</td> <td>I. <input type="checkbox"/> Split Dollar</td> </tr> <tr> <td>C. <input type="checkbox"/> Deferred Compensation</td> <td>G. <input type="checkbox"/> Section 79 (1-9 Plan Participants)</td> <td>J. <input type="checkbox"/> 412(e)(3)</td> </tr> <tr> <td>D. <input type="checkbox"/> Other _____</td> <td>K. <input type="checkbox"/> 419(e) Welfare Benefit Plan</td> <td></td> </tr> </table>					A. <input type="checkbox"/> Buy/Sell	E. <input type="checkbox"/> Employee Benefit	H. <input type="checkbox"/> Section 79 (10+ Plan Participants)	B. <input type="checkbox"/> Controlled Executive Bonus Plan	F. <input type="checkbox"/> Key Employee	I. <input type="checkbox"/> Split Dollar	C. <input type="checkbox"/> Deferred Compensation	G. <input type="checkbox"/> Section 79 (1-9 Plan Participants)	J. <input type="checkbox"/> 412(e)(3)	D. <input type="checkbox"/> Other _____	K. <input type="checkbox"/> 419(e) Welfare Benefit Plan																															
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<p>List additional key person information in Remarks Section.</p>	<p>2. PRINCIPAL OFFICERS, PARTNERS, OR KEY EMPLOYEES' INFORMATION</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;">Name: First</th> <th style="width:15%;">MI</th> <th style="width:40%;">Last</th> <th style="width:15%;">Position</th> <th style="width:10%;">% of Business Owned</th> <th style="width:15%;">Amount of Insurance Owned by Business</th> </tr> </thead> <tbody> <tr><td>A.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>B.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>C.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>D.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>E.</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>F.</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Name: First	MI	Last	Position	% of Business Owned	Amount of Insurance Owned by Business	A.						B.						C.						D.						E.						F.					
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	<p>3. What is the current value of the business? \$ _____</p>		<p>4. What was the annual net profit (before taxes) of business? Last Year \$ _____ 2 Years Ago \$ _____</p>																																												
	<p>5. Are other officers, partners, or key employees proportionately insured? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in Remarks)</p>																																														

**JUVENILE/DEPENDENT INSURANCE INFORMATION**

<p><b>JUVENILE/DEPENDENT INSURANCE</b> Complete if the Proposed Insured is under age 16, and over age 16 if a dependent.</p>	<p>1. Did you personally observe the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in Remarks)</p> <p>2. Are the Proposed Insured's siblings insured for equal amounts? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain in Remarks)</p>																																		
	<p>3. PERSON SUPPORTING PROPOSED INSURED</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">A. Name: First</td> <td style="width:15%;">MI</td> <td style="width:40%;">Last</td> <td colspan="3"></td> </tr> <tr> <td>B. Relationship to Insured</td> <td colspan="2"></td> <td>C. Estimated annual income</td> <td colspan="2"></td> </tr> <tr> <td>D. Estimated net worth</td> <td colspan="2"></td> <td>E. Estimated amount of life insurance</td> <td colspan="2"></td> </tr> <tr> <td></td> <td colspan="2"></td> <td>\$</td> <td colspan="2"></td> </tr> <tr> <td></td> <td colspan="2"></td> <td>\$</td> <td colspan="2"></td> </tr> </table>					A. Name: First	MI	Last				B. Relationship to Insured			C. Estimated annual income			D. Estimated net worth			E. Estimated amount of life insurance						\$						\$		
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			\$																																
D. Purpose of Insurance																																			

**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**PRODUCER INFORMATION (Continued)**

		YES	NO											
<b>PRODUCER REPORT</b> To be answered by the soliciting Producer.	1. Did you personally meet with all parties who have signed this application and ask the appropriate parties all applicable questions in this application? (If no, explain in Remarks Section)	<input type="checkbox"/>	<input type="checkbox"/>											
	2. Indicate the form of valid identification used to confirm the identity of each person signing this application (Check all that apply) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Individual Person</th> <th style="width: 50%;">Non-Individual Entity</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Drivers License</td> <td><input type="checkbox"/> Business License</td> </tr> <tr> <td><input type="checkbox"/> Government Issued Photo ID</td> <td><input type="checkbox"/> Certified Articles of Incorporation</td> </tr> <tr> <td><input type="checkbox"/> Passport</td> <td><input type="checkbox"/> Partnership Agreement</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td><input type="checkbox"/> Trust Document</td> </tr> <tr> <td></td> <td><input type="checkbox"/> _____</td> </tr> </tbody> </table>	Individual Person	Non-Individual Entity	<input type="checkbox"/> Drivers License	<input type="checkbox"/> Business License	<input type="checkbox"/> Government Issued Photo ID	<input type="checkbox"/> Certified Articles of Incorporation	<input type="checkbox"/> Passport	<input type="checkbox"/> Partnership Agreement	<input type="checkbox"/> _____	<input type="checkbox"/> Trust Document		<input type="checkbox"/> _____	
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Explain all "Yes" answers in Remarks Section unless instructed otherwise.	3. Are you aware of any information not given in the application that might affect the insurability of the Proposed Insured(s)?	<input type="checkbox"/>	<input type="checkbox"/>											
	4. Did the Proposed Insured/Additional Insured change his/her name during the past 5 years? If yes, give former name(s): _____	<input type="checkbox"/>	<input type="checkbox"/>											
	5. Certain states require replacement forms for any in force policies even if a replacement is not intended. <p>A. Is there any existing or pending life insurance or annuities on any Proposed Insured?</p>	<input type="checkbox"/>	<input type="checkbox"/>											
	<p>B. To the best of your knowledge, will the policy applied for replace, cause a change in, or involve a cash withdrawal or loan from or lapse of any life insurance policy or annuity contract on any Proposed Insured's life or in any life insurance or annuity owned by the Applicant, or is the policyowner considering using funds from existing policies to pay premiums on the new policy?</p> <p>C. I have discussed the appropriateness of replacement, and followed appropriate state laws, Pacific Life's written replacement guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If no, explain in Remarks Section)</p>	<input type="checkbox"/>	<input type="checkbox"/>											
Small group is defined as more than 1 and less than 10 lives with a common applicant and/or policyowner	6. Have plans been made that any other party (including a Life Settlement and/or Viatical Company), other than the owner, will obtain any right, title or interest in any policy issued on the life of the Proposed Insured as a result of this application?	<input type="checkbox"/>	<input type="checkbox"/>											
	7. What type of case is this application? <input type="checkbox"/> Individual <input type="checkbox"/> Joint Life <input type="checkbox"/> Multilife <input type="checkbox"/> Small Group: Total Number of applications _____ Include Proposed Insured's name(s) in Remarks Section.													
	8. Is this policy going to be used in a qualified plan? <input type="checkbox"/> Yes (If yes, indicate type below and complete additional applicable forms) <input type="checkbox"/> Defined Benefit Plan <input type="checkbox"/> Pension <input type="checkbox"/> Profit Sharing <input type="checkbox"/> 412(e)(3) <input type="checkbox"/> Other _____ <input type="checkbox"/> No													
	9. Check appropriate items that have been ordered: <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Medical Exam</td> <td><input type="checkbox"/> H.O. Specimen</td> </tr> <tr> <td><input type="checkbox"/> Paramedical Exam</td> <td><input type="checkbox"/> Inspection Report</td> </tr> <tr> <td><input type="checkbox"/> EKG</td> <td><input type="checkbox"/> APS _____</td> </tr> <tr> <td><input type="checkbox"/> Blood Profile</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Medical Exam	<input type="checkbox"/> H.O. Specimen	<input type="checkbox"/> Paramedical Exam	<input type="checkbox"/> Inspection Report	<input type="checkbox"/> EKG	<input type="checkbox"/> APS _____	<input type="checkbox"/> Blood Profile	_____					
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**REMARKS – IDENTIFY QUESTION AND GIVE DETAILS**

**PRODUCER COMMISSION INFORMATION**

<b>PRODUCER'S INFORMATION</b> The first name listed will be the servicing producer.  If more than three producers, use Remarks.	<b>SERVICING PRODUCER</b>			
	Name: First MI Last			Soc. Sec. # / Tax ID #
	E-mail Address		Telephone # (include area code)	Fax # (include area code)
	RLO or PL Servicing Office #	Producer Code	Commission %	Commission Payout Choice* (select one) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
	<b>ADDITIONAL PRODUCER</b>			
	Name: First MI Last			Soc. Sec. # / Tax ID #
	E-mail Address		Telephone # (include area code)	Fax # (include area code)
	RLO or PL Servicing Office #	Producer Code	Commission %	Commission Payout Choice* (select one) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
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E-mail Address		Telephone # (include area code)	Fax # (include area code)	
RLO or PL Servicing Office #	Producer Code	Commission %	Commission Payout Choice* (select one) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	

\*Commission Payout Choice A & C are not available on all products. If no choice is indicated, commission payout choice B will be applied unless your broker-dealer has pre-selected a different payout choice. Please verify with your broker-dealer to ensure correct choice is indicated.

<b>BROKER-DEALER'S INFORMATION</b>	<b>BROKER-DEALER</b>	
	Name:	
	Name of Office Contact:	Broker-Dealer Client Account # (if available)

**SOLICITING PRODUCER'S CERTIFICATION**

I certify that to the best of my knowledge and belief:

1. I have presented to the Company all pertinent facts and have correctly and completely recorded all required answers.
2. I have given the Proposed Insured(s) (or Parent for Juvenile insurance) a copy of the Disclosure Notice, and any other disclosure notice, statement or information required by state or federal law.
3. If applicable, I have fully explained the terms and conditions of the Temporary Insurance Agreement to the Proposed Insured(s) (or policyowner) and have given it to him/her (them).
4. I have complied with all applicable state and/or federal laws in the recommendation and/or sale of this policy. I have also complied with Pacific Life's procedures on cost comparison, illustration, and replacement.
5. The information contained in the section "Illustration Acknowledgment" is accurate and true.
6. I have reviewed this Application, and have determined that its proposed purchase is suitable as required under law, based in part upon information provided by the Applicant, Policyowner and Proposed Insured, as applicable, including age, income, net worth, tax and family status, and any existing insurance program. If the policy applied for is a variable life insurance policy, I further certify that I have also considered the Policyowner's liquidity needs, risk tolerance, and investment time horizon, and followed my broker-dealer's suitability guidelines in both the recommendation of this policy, and the choice of investment options.
7. Only sales materials provided or otherwise approved by Pacific Life were used in the sales process and copies of all sales material were left with the applicant.
8. I am appropriately state licensed and appointed in all jurisdictions in which sales activity (including solicitation, obtaining application signatures, and policy delivery) related to this application has taken or will take place.
9. If any person is an active duty member of the United States Armed Forces (including active duty military reserve personnel), I certify that this application was not solicited and/or signed on a military base or installation, and I provided to the applicant the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.

Signed and Dated by the Soliciting Producer on: \_\_\_\_\_ (mm/dd/yyyy)

 **X**

MUST MATCH THE SOLICITING PRODUCER ON THE APPLICATION'S SIGNATURE PAGE.

**Soliciting Producer's Signature**

**ADDITIONAL PRODUCER'S CERTIFICATION (Required if personally meeting with the client during solicitation or policy delivery.)**

I am appropriately state licensed and appointed in all jurisdictions in which sales activity (including solicitation, obtaining application signatures, and policy delivery) related to this application has taken or will take place.

Signed and Dated by the Additional Producer(s) on: \_\_\_\_\_ (mm/dd/yyyy)

 **X**

**Additional Producer's Signature** **Additional Producer's Signature**

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**PACIFIC LIFE INSURANCE COMPANY**

[Life Insurance Operations Center  
P.O. Box 2030 • Omaha, NE 68103-2030  
(800) 347-7787 • Fax (949) 462-3066  
www.PacificLife.com]

**DISCLOSURE NOTICE****DETACH AND LEAVE WITH PROPOSED INSURED(S)**

This brief description of our underwriting process is designed to help you to understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right, or your authorized representative's right, to learn the nature and substance of that information upon written request. The purpose of the underwriting process is to make sure you qualify for life insurance under the rules of Pacific Life Insurance Company (PL), and assuming you do, establish the proper premium charge for that insurance. The goal of the underwriting process is to have the cost of insurance distributed equitably among all policyowners, so that each individual pays his or her fair share. To determine your insurability, we must consider such factors as your medical history, physical condition, occupation, and hazardous avocations. We get this information from various sources.

**Application and Medical Records** – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or the Medical Information Bureau, Inc. When we do so, we will use the Authorization To Obtain Information that you signed.

**Medical Information Bureau, Inc. (MIB)** – is a non-profit corporation, which operates an information exchange on behalf of member life insurance companies. As a member company, we will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability. The information, which is obtained from MIB, may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis to make a final underwriting decision. Information regarding your insurability will be treated as confidential. PL, its subsidiaries, or its reinsurer(s) may, however, make a brief report to the MIB. If you later apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply the company with the information it may have about you in its file. PL, its subsidiaries, or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. At your request, or your authorized representative's request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the information office of MIB, Inc., is [Post Office Box 105, Essex Station, Boston, Massachusetts 02112]. Their telephone number is [(866) 692-6901].

**Investigative Consumer Report** – As part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application pertaining to employment and residence verification, smoking habits, marital status, occupation, hazardous avocations, and general health. This report may also cover information concerning your general reputation, personal characteristics, and mode of living (except as may be related directly or indirectly to your sexual orientation) including drug and alcohol use, motor vehicle driving record, and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors, and business associates. If a report is required and you wish to be personally interviewed, please let us know and we will notify the consumer reporting agency. The information contained in the report may be retained by the consumer reporting agency and subsequently disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. Investigative consumer reports are held in strict confidence and used only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of the report from the consumer reporting agency.

**DISCLOSURE TO OTHERS**

Personal information obtained about you during the underwriting process and at other times is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business and only to the extent permitted by applicable state law. Examples of situations where we may share information about you are as follows:

- The Producer may retain a copy of your application, and after a policy is issued will have access to ongoing policy information in order to better serve your needs.
- If reinsurance is required, the reinsurance company would have access to our application file.
- We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized it to obtain such information.
- As stated earlier, we may report information to the Medical Information Bureau, Inc.
- We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

**DISCLOSURE TO YOU**

In general, you have a right to learn the nature and substance of any personal information about you in our file upon written request. Whenever an adverse underwriting decision is made, we will notify you of the reason(s) for the decision and the source of the information upon which our action is based. Medical record information, however, will normally be given only to a licensed physician of your choice. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. Should you feel that any information we have is inaccurate or incomplete, please write to: Manager, New Business Services, PL Insurance Company, [P.O. Box 2030, Omaha, NE 68103-2030]. Your comments will be carefully considered and corrections made where justified. We hope this Notice will help you to understand how we obtain and use personal information in the underwriting process, and the ways you can learn about this information. We are concerned with insuring privacy as well as lives, and the collection, use, and disclosure of personal information is limited to those specified in this Notice.