

<i>SERFF Tracking Number:</i>	<i>AEMN-127296699</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>RiverSource Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49998</i>
<i>Company Tracking Number:</i>	<i>134886AR</i>		
<i>TOI:</i>	<i>L06I Individual Life - Variable</i>	<i>Sub-TOI:</i>	<i>L06I.002 Single Life - Flexible Premium</i>
<i>Product Name:</i>	<i>Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Life/DI 2011 Application/134886</i>		

Filing at a Glance

Company: RiverSource Life Insurance Company

Product Name: Life Insurance

SERFF Tr Num: AEMN-127296699 State: Arkansas

TOI: L06I Individual Life - Variable

SERFF Status: Closed-Approved-
Closed State Tr Num: 49998

Sub-TOI: L06I.002 Single Life - Flexible
Premium

Co Tr Num: 134886AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Debbie Berg, Bonnie

Disposition Date: 10/14/2011

Foley, Jeff Pederson, Cheryl Meyer

Date Submitted: 10/10/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life/DI 2011 Application

Status of Filing in Domicile: Pending

Project Number: 134886

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filing to domicile
state of Minnesota will be submitted in next 2-3
weeks.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/14/2011

State Status Changed: 10/14/2011

Deemer Date:

Created By: Debbie Berg

Submitted By: Debbie Berg

Corresponding Filing Tracking Number:

Filing Description:

RE: RiverSource Life Insurance Company

Individual Life Insurance Application Form Filing

..Form 134886 - Individual Life and Disability Income Insurance Application

.....(To replace Form 134851 approved on 02/17/2010 as file no. 44823.)

..Form 131244 - Electronic Signature (New form - none replaced)

SERFF Tracking Number: AEMN-127296699 State: Arkansas
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TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2011 Application/134886

This new Life and DI application form and Electronic Signature form are submitted for review and approval by your department. We plan to begin using these forms in the 1st quarter of 2012.

The submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. The application has been reformatted to accommodate the advisor using a computer-based forms completion tool to obtain and pre-fill the application form. The tool will then render the application form and any other required documents for review and signature in paper or PDF format. The application itself will retain the pertinent product-specific sections but have extraneous sections removed as explained in the Statement of Variability.

The PDF format will provide a client the choice of applying an electronic signature to the form. We certify that the electronic signature protocols to be used with the application form and acknowledgement form are compliant with the Electronic Signatures in Global and National Commerce Act (ESIGN) and with state Uniform Electronic Transaction Act (UETA) laws. After electronic signature is completed, a copy of the Electronic Signature form 131244 will be included in the policy delivered to the owner to depict a record of the eSign process.

New base application 134886 will be used in conjunction with the following supplemental application forms approved on 02/17/2010 as file no. 44823.

Form 133081 - Insurance Application Supplement – Part Two is used for all product sales. It is completed separately from the base application via a telephone interview by someone other than the advisor.

Form 132263 - AdvanceSource® Accelerated Benefit Rider application is used in addition to base application for selecting an AdvanceSource® Rider. To be completed in the same manner as base application 134886.

Other minor changes to the application forms include:

- Updated the Life Insurance Plan and Riders section to reflect current products.
- Text revision intended to clarify questions or instructions.

The new application form will be used to apply for previously approved life and/or disability income insurance policies/products. A Forms List of those policies to which the application will be attached is provided in supporting documents. The application form is exempt from state and NAIC Readability requirements because it is used with variable life policies subject to SEC jurisdiction.

Material that may change is indicated by brackets on the submitted forms. A Statement of Variability describing the bracketed items is attached in supporting documents. The submitted forms have also been annotated to easily match the bracketed items to the explanations in the Statement of Variability.

To the best of our knowledge, this form complies with the laws and regulations of Arkansas. Any applicable certifications as required by your state are provided as supporting documents. Thank you for your consideration of this

SERFF Tracking Number: AEMN-127296699 State: Arkansas
 Filing Company: RiverSource Life Insurance Company State Tracking Number: 49998
 Company Tracking Number: 134886AR
 TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
 Product Name: Life Insurance
 Project Name/Number: Life/DI 2011 Application/134886

filing. Please feel free to call or send me an email if there is any assistance I can provide to facilitate your review.

Debbie Berg
 612-671-2965
 debbie.berg@ampf.com

Company and Contact

Filing Contact Information

Debbie Berg, Sr. Contract Analyst debbie.berg@ampf.com
 9550 Ameriprise Financial Center 612-671-2965 [Phone]
 H25/9550 612-671-3866 [FAX]
 Minneapolis, MN 55474

Filing Company Information

RiverSource Life Insurance Company CoCode: 65005 State of Domicile: Minnesota
 9550 Ameriprise Financial Center Group Code: 4 Company Type: Life
 H25/9550 Group Name: State ID Number:
 Minneapolis, MN 55474 FEIN Number: 41-0823832
 (612) 671-2465 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$125.00
 Retaliatory? Yes
 Fee Explanation: AR Fee is \$50 for each form filed separately from policy - 2 x 50 = \$100.
 MN filing fee is \$125 per filing.
 Submitted retaliatory fee of \$125.00 via EFT.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
RiverSource Life Insurance Company	\$125.00	10/10/2011	52660624

SERFF Tracking Number: AEMN-127296699 State: Arkansas
Filing Company: RiverSource Life Insurance Company State Tracking Number: 49998
Company Tracking Number: 134886AR
TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2011 Application/134886

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/14/2011	10/14/2011

SERFF Tracking Number: AEMN-127296699 *State:* Arkansas
Filing Company: RiverSource Life Insurance Company *State Tracking Number:* 49998
Company Tracking Number: 134886AR
TOI: L06I Individual Life - Variable *Sub-TOI:* L06I.002 Single Life - Flexible Premium
Product Name: Life Insurance
Project Name/Number: Life/DI 2011 Application/134886

Disposition

Disposition Date: 10/14/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEMN-127296699 State: Arkansas
 Filing Company: RiverSource Life Insurance Company State Tracking Number: 49998
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 TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
 Product Name: Life Insurance
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	2011 Life-DI App SOV		No
Supporting Document	Forms List		No
Form	Individual Life and Disability Income Insurance Application		No
Form	Electronic Signature		No

SERFF Tracking Number: AEMN-127296699 State: Arkansas
 Filing Company: RiverSource Life Insurance Company State Tracking Number: 49998
 Company Tracking Number: 134886AR
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Form Schedule

Lead Form Number: 134886

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	134886	Application/ Enrollment Form	Individual Life and Disability Income Insurance Application	Initial		0.000	134886_Life-DI Application JD-Brktd.pdf
	131244	Other	Electronic Signature	Initial		0.000	131244_Elec Sign John Doe-Brkts.pdf



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application



D. Always complete Insured Information.

Reference Number 1234 1234567 1 001
Client ID 10000001 3

INSURED INFORMATION

1. Insured:

Insured's Name (First, Middle Initial and Last Name) Male Female

John Q Doe

Insured's Phone Number (Day)
(612) 871-4444

Insured's Phone Number (Evening)
(952) 435-8888

Is Insured the Owner? Yes No If you answered "No" complete this page and Owner Information section.

Citizenship: U.S. Other: If Other, Insured is: Resident Alien Resident Alien with Green Card Nonresident Alien

Birth Date (MMDDYYYY) 05 02 1962 State of Birth or Country of Birth OH U.S. Social Security Number 123-45-6789

Driver's License (DL) Number 1000001 DL State of Issuance MN Occupation Insurance Underwriter

Employer Name RiverSource Insurance Individual Income \$ 50,000.00 Net Worth \$ 100,000.00 Household Income \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY) 05 1992
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Dr. James Smith Date Last Seen (MMYYYY) 12 2010

Street Address 123 Main St City Edina State MN ZIP Code 55000 Phone (612) 555-1000

3. Premium Submitted:

Do not include any premium with this application if you:

- answered "Yes" to 2a or 2b above; or
- answered "Yes" to 2a or 2b in the Second Insured section (if Succession Protector or Succession Select product applied for); or
- are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$

If one check is submitted for multiple products, please specify the dollar amount to each product.



Complete all applicable sections. **D.**

JUVENILE INSURANCE (Complete if insured is under age 15.) **D.**

Is there similar insurance in force or applied for on all siblings? Yes No If no, why?

Amount of life insurance already in force on the person responsible for child's primary support \$

OWNER INFORMATION (Complete if Owner is different from Insured as shown in the Insured Information section.) **D.**

Individual - Name (First, Middle Initial and Last Name)

U.S. Social Security Number Birth Date (MMDDYYYY)

Male Female

Citizenship: U.S. Other:

If Other, Owner is:

- Resident Alien
- Resident Alien with Green Card
- Nonresident Alien

Relationship to Insured

Does the Owner wish to designate a Successor Owner? Yes No

If Yes, Successor Owner's Name

Relationship to Owner

Trust - Name of Trust

Revocable - Grantor's Taxpayer Identification Number (TIN)

Irrevocable - Trust's TIN

Name of Trustee

Date of Trust (MMDDYYYY)

Address of Trustee

City

State

ZIP Code

Business or Other Entity - Name

TIN

Relationship to Insured

Federal Tax Classification (if not an individual or trust, above.):

Sole Proprietor Partnership S-Corporation C-Corporation Estate

Limited Liability Company (LLC) (enter the tax classification: Partnership S-Corporation C-Corporation)

Other

Check here if Owner is an Exempt Payee (defined in IRS Form W-9 instructions)

BUSINESS INSURANCE (Complete if insurance is for business purposes.) **D.**

Type of Business Insurance: Buy/Sell Business Debt Protection Split Dollar Key Person

Executive Bonus/GEBA Deferred Compensation (nongovernmental)

Other



Complete all sections for life insurance products. **D.**

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No

If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	019874320	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	JK0198743	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	0198430 04132	whole Term	50,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10980431	Mortgage	88,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.

AGREEMENT TO SELL, TRANSFER OR ASSIGN LIFE INSURANCE

Any "party" to the application is defined as the insured, owner or any beneficiary. "Third Party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider or premium financing entity.

1. Agreements or Incentives — Has any Party to the application:

- Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
- Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the applied for policy; or
- Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the applied for policy? Yes No

2. Prior Transactions — Has any Party to the application ever:

- Sold, transferred or assigned any life insurance policy to a Third Party; or
- Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign any life insurance policy? Yes No

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.



Complete for term life insurance products. **D.**

LIFE INSURANCE PLAN INFORMATION: Term Life Insurance

1. Life Insurance Plan Information

F.

- a. Level Term Plans: 20-Year 15-Year 10-Year
 Insured Amount \$
- b. Income Protection Life Plans: Term to Age 60 Term to Age 65 Term to Age 67
 Monthly Death Benefit Amount is \$
- c. Other Insured Amount \$

2. Riders/Options

H.

- Level Term
- Waiver of Premium
 - Accidental Death Benefit of \$
 - Children's Insurance Rider (CIR) Units Provide details in CIR section.
- Income Protection Life
- Waiver of Premium
 - Cost of Living Adjustment
 - Other

3. Life Insurance Premiums

- Annual Premium
 \$
- a. Bank Authorization (BA): Monthly Quarterly
 New BA Authorization (Complete Form 200517.)
 Add to Existing BA with Account Number
 - b. Systematic Payment Option (SPO) (Complete Form 200517.)
 - c. Direct Bill: Quarterly Semiannually Annually
 - d. Card Billing: MasterCard American Express Visa Discover
 Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually
 Card Number Expires Do not add security code.
 - e. Other:

4. Life Insurance Beneficiary — Term Insurance

- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.
 Insured's Spouse's Full Name
- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.
 Insured's Spouse's Full Name
- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)



D. Complete for universal life and variable universal life insurance products.

LIFE INSURANCE PLAN INFORMATION: Universal Life and Variable Universal Life

1. Life Insurance Plan Information Insured Amount \$ _____ Purpose of Insurance _____

- F.**
- Foundations Protector (FP)
 - Foundations Universal Life (FUL): Death Benefit Option: 1 (Level) 2 (Variable)
 Life Insurance Qualification Test: Guideline Premium Test Cash Value Accumulation Test
 (If nothing is chosen, default is Guideline Premium Test.)
 - Indexed Universal Life (IUL): Death Benefit Option: 1 (Level) 2 (Variable)
 Life Insurance Qualification Test: Guideline Premium Test Cash Value Accumulation Test
 (If nothing is chosen, default is Guideline Premium Test.)
 Premium Allocation: Fixed Account _____ % Indexed Account _____ %
 (Total must equal 100%. If no percentage indicated, default is Fixed Account 100% and Indexed Account 0%.)
 Segment Maturity Reallocation: Fixed Account _____ % Indexed Account _____ %
 (Total must equal 100%. If no percentage indicated, default is Fixed Account 0% and Indexed Account 100%.)
 - Variable Universal Life (VUL): Death Benefit Option: 1 (Level) 2 (Variable)
 Complete the Variable Product Information section AND Investment Option Allocation
 Form 33034 OR Portfolio Navigator Enrollment Form 402048.
 - Other _____

2. Riders/Options

- H.**
- Accelerated Benefit Rider for Terminal Illness
 - AdvanceSource* Rider - Complete *AdvanceSource* Rider application.
 - Waiver of Monthly Deduction (FUL, IUL, VUL only)
 - Waiver of Specified Premium - Monthly Specified Premium \$ _____ (FUL, IUL, VUL only)
 - Accidental Death Benefit of \$ _____ (FUL, IUL and VUL only)
 - Children's Insurance Rider (CIR) Units _____ (FUL, IUL, VUL only) Provide details in the CIR section.
 - Automatic Increase Benefit Rider: (FUL, IUL, VUL only) 2% 3% 4% 5% 6% 7% 8%
 - Other _____

3. Life Insurance Premiums

Annual Scheduled Premium Lump-Sum Amount to Be Paid on Delivery of Policy
 \$ _____ \$ _____

a. Bank Authorization (BA): Monthly Quarterly
 New BA Authorization (Complete Form 200517.)
 Add to Existing BA with Account Number _____

b. Systematic Payment Option (SPO) (Complete Form 200517.)

c. Direct Bill: Quarterly Semiannually Annually

d. Other _____

4. Life Insurance Beneficiary - Universal Life and Variable Universal Life

- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.
 Insured's Spouse's Full Name _____
- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.
 Insured's Spouse's Full Name _____
- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)



Complete for Succession Protector and Succession Select products. **D.**

LIFE INSURANCE PLAN INFORMATION: Succession Protector and Succession Select

1. Life Insurance Plan Information Insured Amount \$ Purpose of Insurance

F. Succession Protector
 Succession Select - **must select Option 1 or 2 for this plan:**
 Death Benefit Option 1 (Level) Death Benefit Option 2 (Variable)
 Complete the Variable Product Information section AND Investment Option Allocation Form 33034 OR Portfolio Navigator Enrollment Form 402048.
 Other

2. Riders/Options
H. Four Year Term of \$
 Policy Split Option
 Other

3. Life Insurance Premiums
 Annual Scheduled Premium Lump-Sum Amount to Be Paid on Delivery of Policy
 a. Bank Authorization (BA): Monthly Quarterly
 New BA Authorization (Complete Form 200517.)
 Add to Existing BA with Account Number
 b. Systematic Payment Option (SPO) (Complete Form 200517.)
 c. Direct Bill: Quarterly Semiannually Annually
 d. Other

4. Survivorship Beneficiary Designation
 Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)

Complete for Variable Universal Life and Succession Select products. **D.**

VARIABLE PRODUCT INFORMATION **VAR: Page 6 (bottom) info prints only for variable products.**

1. Variable Universal Life and Succession Select Information - Check each of the following below to indicate your acknowledgement: (Also, complete Investment Option Allocation Form 33034 or Portfolio Navigator Enrollment Form 402048.)

Adequate Information. You have received the current prospectuses for the policy applied for and any funds involved.

Purpose. You agree that this variable type of insurance is in accord with your insurance and financial objectives.

Variable values. You understand that the amount of Death Benefit and Policy Value can both increase and decrease; however, the Death Benefit will never be less than any Guaranteed Minimum Death Benefit.

Fees and Charges. The fees and charges have been explained to you and are also explained in detail in the policy.

2. Consent for Delivery of Initial Prospectuses on CD-ROM
 Yes - By checking this box, I acknowledge that I have chosen to receive and have received the initial product and fund prospectuses on computer readable compact disk ("CD"). See details in Consent for Delivery of Initial Prospectus on CD-ROM section.



Complete for disability income insurance products. **D.**

DISABILITY INCOME PLAN INFORMATION

1. Disability Income Insurance Plan Information

Base Monthly Benefit

\$ _____

Insured's Occupation Class:

- 1A 2A 3A 3M
- 4A 4M 5A 5M

Waiting Period:

- 30 days 60 days 90 days
- 180 days 365 days

Duration of Benefit: 1 year 3 year 5 years to age 65 to age 67

Premium Pattern: Level Step Rate

Disability Provision:

G.

- Occupation Classes 1A, 2A, 3A & 3M Income Protection Plus with 2 Years Occupation Protection (IPP-2)
- Occupation Classes 4A, 4M, 5A & 5M Income Protection Plus with 5 Years Occupation Protection (IPP-5)
- Occupation Classes 4A & 5A Income Protection Plus (IPP)
- Occupation Classes 4A, 4M, 5A & 5M Income Protection with Residual Benefits (IPTr)
- Occupation Classes 3A, 4A, 4M, 5A & 5M Income Protection (IPMod)

Group Rate Options — Please indicate below ONLY if either of the following applies to this application.

- Employer Plan Coverage Unisex Rates
- Multiple Case Discount (See online reference materials for all qualification details.)

2. Disability Income Insurance Riders/Options

H.

- Social Benefits Rider \$ _____ per month with Waiting Period of _____ days
- Supplemental Income Rider \$ _____ per month and benefit paid up through month _____ with _____ day waiting period
- Cost of Living Adjustment Maximum (classes 2A, 3A, 3M, 4A, 4M, 5A, and 5M)
Maximum: 3% 4% 5% 6% 7% 8% 9% 10%
- Future Purchase Option \$ _____ Pool Amount
- Other _____

3. Disability Income Insurance Premiums

Annual Premium \$ _____

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number _____

b. Special Payment Option SPO (Systematic Payout) Complete Form 200517

c. Direct Bill: Quarterly Semiannually Annually

d. Card Billing: MasterCard American Express Visa Discover

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number _____ Expires _____ Do not add security code.

e. Other _____



Complete for business overhead expense products. **D.**

BUSINESS OVERHEAD EXPENSE PROTECTION PLAN INFORMATION

1. Business Overhead Expense Protection Insurance Plan

(Cannot be applied for without personal disability income protection in force or applied for with RiverSource Life or other company.)

Complete Disability Underwriting Information section.

Monthly Benefit \$

Insured's Occupation Class: 3A 3M 4A 4M 5A 5M

Waiting Period: 30 days 60 days 90 days

Benefit Pattern: Level Increasing

Multiple DI Case Discount (See online reference materials for all qualification details.)

2. Business Overhead Expense Protection Insurance Premiums

Annual Premium \$

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number

b. Special Payment Option SPO (Systematic Payout) Complete Form 200517.

c. Direct Bill: Quarterly Semiannually Annually

d. Card Billing: MasterCard American Express Visa Discover

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number Expires Do not add security code.

e. Other

Complete for disability income and business overhead expense products. **D.**

DISABILITY UNDERWRITING INFORMATION

1. Are you currently actively employed? Yes No

a. If yes, number of hours per week Number of weeks per year

b. Self-employed? Yes No If yes:

i. Date business began (MMDDYYYY)

ii. Type of business or industry

- iii. Type of business entity: Sole Proprietorship
- S Corporation
- Partnership
- C Corporation
- Limited Liability Corporation
- Other

Disability Underwriting Information Continued on next page...



Disability Underwriting Information Continued

2. Occupational Duties

a. Provide a complete description of your job duties. Include a percentage of time spent on each task.

b. Do you manage or supervise others? Yes No

If yes, what percent of duties are supervisory? % Number of employees

c. Provide any professional designations or educational degrees you hold which are specific to your occupation.

3. Any contemplated change in occupation?

Yes No If yes, explain:

4. Previous occupation if changed in the past five years

5. Amount of unearned income \$ **Source**

6. Is the Insured a member of a State, Public, or Federal Retirement System?

Yes No If yes, which one?

7. Is the Insured eligible for or does the insured have any disability income insurance through his/her employer?

a. Short-term: Yes No at \$ per month for months and day waiting period

b. Long-term: Yes No at \$ per month for months and day waiting period

c. If yes to b., is the group long-term disability integrated with Social Security? Yes No

d. Will the Insured's employer be paying the premiums for the RiverSource Life disability insurance? Yes No

e. Is the Insured eligible for benefits from a required state Cash Sickness disability program? Yes No

8. Existing Disability Income Insurance (all applicants must complete)

Insured: Do you have any other disability insurance currently in force or applied for? Yes No

If yes, you must complete all details in the grid below even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Insurance Amount/ Monthly Income	Being Replaced
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No

Use the Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life disability policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.



Complete for Succession Protector and Succession Select life insurance products. **D.**

SECOND INSURED

1. Second Insured:

Second Insured's Name (First, Middle Initial and Last Name) Male Female

JUnY Q Doe

Second Insured's Phone Number (Day) Second Insured's Phone Number (Evening)

(612) 871-4444 (612) 555-4321

Citizenship: U.S Other: If Other, Second Insured is: Resident Alien
 Resident Alien with Green Card
 Nonresident Alien

Relationship to Insured

wife

Birth Date (MMDDYYYY) State of Birth or Country of Birth U.S. Social Security Number
 07 15 1964 MN 234-56-7890

Driver's License (DL) Number DL State of Issuance Occupation
 1200000002 MN Elementary Teacher

Employer Name Individual Income Net Worth Household Income
 Richfield ISD \$ 50,000.00 \$ 100,000.00 \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Second Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Second Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the Second Insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
 05 1986
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Date Last Seen (MMYYYY)
 Dr. William Johnson 05 2011

Street Address City State ZIP Code Phone
 246 Oak St Edina MN 55000 (612) 444-2000



Complete for Succession Protector and Succession Select life insurance products. **D.**

EXISTING LIFE INSURANCE OR ANNUITIES

SECOND INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No

If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	019874321	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	JK0198744	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	0198430 0413	Whole Life	50,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10980431	Mortgage	88,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.



- Complete Children's Insurance Rider section if CIR is applied for.
- Complete the Notes section for additional information for all products.



CHILDREN'S INSURANCE RIDER INFORMATION

1. Name(s) of child(ren) to be covered by rider (must be under age 19 and unmarried):

Name (First, Full Middle, Last)	Birth Date (MMDDYYYY)	Sex	Physical/Mental Abnormalities at Birth?
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No

2. Has anyone listed above received treatment for any disease, physical or mental condition in the past five years?
 Yes No

3. Is this insurance intended to replace any existing insurance and/or annuity? Yes No

4. If "Yes" was checked for 1, 2 or 3 above, explain here:

5. Are there any children under the age of 19 and unmarried not listed above? Yes No

If "Yes" list name: Birth Date (MMDDYYYY)

Reason for exclusion

NOTES

(Include details to any "Yes" answers or any additional replacement or other information.)



INSURED INFORMATION
 2. Coverage Questions:
 a. Hospitalized for appendectomy on 01 2011. Fully recovered.

EXISTING LIFE INSURANCE OR ANNUITIES
 (continued)
INSURED:
 Washington Life - 77 777722 - whole Life - \$75,000 - Replace? No
SECOND INSURED:
 Washington Life - 77 777733 - whole Life - \$50,000 - Replace? No

LIFE INSURANCE PLAN INFORMATION: Succession Protector and Succession Select
 4. Survivorship Beneficiary Designation
 (continued)
 Testamentary Trustee(s) named in the Last will and Testament of the Insured, provided that such trustee(s) is(are) duly appointed pursuant to the probate of the will.



●
Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)

E.



●
Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)

E.



Review Disclosures and Notices below.

D.

TERM-DI: Will print only for Term Life or Disability Insurance.

CREDIT OR CHARGE CARD BILLING AGREEMENT

(Not available for initial premium payment. Available with term and disability income insurance products only.)

- By signing for card billing, you authorize RiverSource Life Insurance Company to bill your card account for the insurance premiums and frequency indicated in the Plan Information sections applied for and you understand that payments will be automatically billed to your card account.
- You understand that RiverSource Life Insurance Company may receive updated card account information from your card company.
- You understand you may discontinue this payment at any time. The arrangement will remain in effect until you notify RiverSource Life Insurance Company in writing to cancel it, allowing reasonable time to act on your cancellation. Any such notification shall be effective only with respect to entries initiated after receipt of and reasonable time to act upon such notification, usually 15 days.
- RiverSource Life Insurance Company reserves the right to terminate this agreement at any time upon 30 days written notification.

CD-ROM: Will print only for UL, VUL, SP or SS

CONSENT FOR DELIVERY OF INITIAL PROSPECTUSES ON CD-ROM

I understand that I have the right to receive the prospectuses in paper format, which has been offered to me.

- I have access to and understand how to use the hardware and software that are necessary to view the prospectuses (see CD label for operating requirements).
- I understand that, in order to retain paper copies of the prospectuses, I must either:
 - A. Print the prospectuses found on the CD, incurring any printing costs myself; or
 - B. Request the prospectuses in paper form free of charge by calling Customer Service toll-free at 1(800) 333-3437.
- I understand that all future prospectus updates and supplements will be provided to me in paper form unless I sign up for online document delivery on the My Financial Accounts website at Ameriprise.com.

PROD-ACK: Will print only for UL, VUL, SP or SS

Universal Life/Variable Universal Life/Succession Protector/Succession Select products

If you have applied for this type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition, and the company's revenues and expenses.



STATE FRAUD NOTICES

I.

For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

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

For Applicants in **District of Columbia** only:

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

For Applicants in **Kentucky** only:

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.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

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

For Applicants in **Oklahoma** only:

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

For Applicants in **Tennessee and Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

●

Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

J.

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)

X John Q Doe 09 15 2011

Second Insured's Signature

X Jane Q Doe 09 15 2011

Owner's Signature (other than Insured)

X _____

Parent/Legal Guardian's Signature (for Insureds under age 15)

X _____

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from John Q Doe the sum of \$ 0.00 with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Advisor's Report

AR-COMP

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

AR-SIGS

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name	Advisor Number
Ted Trustworthy	10000000

Advisor's Signature	Date (MMDDYYYY)
X Ted Trustworthy 09 15 2011	09 15 2011

Team ID	Comp %	Phone	Ext	Area Office Number
01000	100.00	(612) 555-1000		91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

i If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Name	Advisor's Number

w It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name	Advisor Number

Advisor Signature	Date (MMDDYYYY)
X	

Team ID	Comp %	Phone	Ext	Area Office Number



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Corporate Office Copy — Submit to Corporate Office



Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

J

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: [] check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
• A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
• An estate (other than a foreign estate), or
• A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print) John Q Doe State MN Signed on Date (MMDDYYYY) 09 15 2011

Insured's Signature (base plan) X John Q Doe 09 15 2011

Second Insured's Signature X Jane Q Doe 09 15 2011

Owner's Signature (other than Insured) X

Parent/Legal Guardian's Signature (for Insureds under age 15) X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor). Received from John Q Doe the sum of \$ 0.00 with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Advisor's Report

AR-COMP

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

AR-SIGS

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name

Ted Trustworthy

Advisor Number

10000000

Advisor's Signature

X Ted Trustworthy 09 15 2011

Date (MMDDYYYY)

09 15 2011

Team ID

01000

Comp %

100.00

Phone

(612) 555-1000

Ext

Area Office Number

91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

i If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Name

Advisor's Number

! It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name

Advisor Number

Advisor Signature

Date (MMDDYYYY)

X

Team ID

Comp %

Phone

Ext

Area Office Number

1.



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

2.



Electronic Signature

Reference Number	9090-1234567-1-004
Client ID	234 5678 1 001

Instructions

1. Review and eSign Document Packet

By Clicking Select All below, you confirm that you have reviewed, understand and accept the entire Document Packet, and you confirm that you wish to utilize your single electronic signature to sign all documents listed below.

Select All

- Life and Disability Income Insurance Application
- Authorization for Release of Health-Related Information to RiverSource Life Insurance Company
- Bank Authorization (BA/Systematic Payout (SPO) form
- HIV Test Informed Consent Form
- AdvanceSource*® Accelerated Benefit Rider Application
- Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance
- Investment Option Allocation
- Portfolio Navigator Program Enrollment/Change Request for Variable Life Insurance
- Incoming 1035 Exchange Request for Nonqualified Insurance and Annuity Products
- Important Notice: Replacement of Life Insurance or Annuities
- Insurance Replacement Disclosure

3.

2. Consent to eSign

This Document Packet, including the terms, conditions and declarations as well as other important documents such as disclosures and agreements were prepared for your review and approval. If the information is accurate and you agree to all terms, conditions and declarations type your name below and click the eSign button to sign all documents selected above utilizing your single electronic signature. You may retain a copy of the Document Packet for your records by saving it electronically to your own personal storage device or by printing the Document Packet.

3. Type your name

John Q. Doe

eSign Decline to eSign Cancel

4.

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5.

<i>SERFF Tracking Number:</i>	<i>AEMN-127296699</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>RiverSource Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49998</i>
<i>Company Tracking Number:</i>	<i>134886AR</i>		
<i>TOI:</i>	<i>L06I Individual Life - Variable</i>	<i>Sub-TOI:</i>	<i>L06I.002 Single Life - Flexible Premium</i>
<i>Product Name:</i>	<i>Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Life/DI 2011 Application/134886</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments: The application forms are exempt from state and NAIC Readability requirements because they are used with variable life policies subject to SEC jurisdiction.		
Attachments: AR CH 19 CERT 134886.pdf AR GTY NOTICE.pdf ARNOTIC2.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: The submitted form is an application and attached in the Form Schedule.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo		
Bypass Reason: NA - There are no policies submitted in the filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: 2011 Life-DI App SOV		
Comments: The attached Statements of Variability provide details regarding all items bracketed as variable . John Doe specimens show the product-specific sections.		
Attachments: SOV 134886 9-15-11.pdf DI John Doe Specimen.pdf SP-SS John Doe Specimen.pdf		

STATE OF ARKANSAS
Life and Disability Income Application
CERTIFICATION OF COMPLIANCE

Forms: **134886** **Life and Disability Income Application Form**
 131244 **Electronic Signature Form**

We certify that the above forms being submitted meet the provisions of Rules 19 of the Arkansas Insurance Department Rules and Regulations as well as all applicable requirements of the Department.

I, Jeffrey R. Pederson, Assistant Secretary of RiverSource Life Insurance Company, further certify that I am familiar with the applicable laws, rules and regulations of the State of Arkansas, and that to the best of my knowledge, information and belief, all forms submitted with this letter are in compliance in all respects with the provisions of the Insurance Laws, Rules and Regulations of the State of Arkansas.



RiverSource Life Insurance Company
Jeffrey R. Pederson, Assistant Secretary

Date: October 10, 2011

Limitations and Exclusions under the Arkansas Life and Disability Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of 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 Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

RiverSource Life Insurance Company
70100 Ameriprise Financial Center
Minneapolis, MN 55474

John Doe
XXXX-XXXXXXXX

Questions Regarding Your Policy?

If you have questions regarding your policy, you may contact the following:

RiverSource Life Insurance Company
Policyowner Service Department
70100 Ameriprise Financial Center
Minneapolis, MN 55474

Tele: 1-800-862-7919 (Hours are 7 am - 8 pm Central Standard time)

Representative Name: John Smith

Representative Address: Ameriprise Financial Services
1234 Main Street
Little Rock, AR 72204

If we at RiverSource Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

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

Tele: 1-800-852-5494

RiverSource Life Insurance Company
Statement of Variability - Form 134886: Life and Disability Insurance Application

Brackets have been placed around various fields in the application form in order to indicate that they are variable and subject to change by us as detailed below.

- Formatting may change due to future changes in typestyle and/or electronic generation of the forms. However, any adaption we make will not involve changes to text without any necessary prior approval and will always meet or exceed the requirements of your state.
- With electronic generation of the application form, only the product-specific section being applied for will generate. Minor formatting, layout or spacing variations may occur to account for text wrapping and the length or amount of information entered in fill-in boxes; however, no text changes will be made without necessary prior approval. John Doe specimens are included for each of the product types.
- We reserve the right to correct typographical errors.

Item (page #)	Field	Scope of Variation
A (page 1)	Copyright Statement	The current copyright statement of "© 2012 RiverSource Life Insurance Company. All rights reserved." Bracketed in case copyright year 2012 changes with future application updates of variable items.
B (all pages)	Page Numbers	Page numbers may shift due to changing or expanding blank lines to allow more or less room. They will also shift if approved products are added or discontinued, and will vary by the amount of space allocated to each category of specific product selection.
C (all pages)	Version letter/print date	The current version letter of A and print date of (03/12) will be changed if any future changes are made to fields bracketed as variable. The date will also be changed if the print or installation dates of the form are more than 1 month beyond the (03/12) date used in the filed version. The date range will also use 1-12 for the months and the last two numbers of a year, from 2012 to future years. The version letter range will be A - Z except never "B, I, O, Q, or S." The numeral 1 in the black circle is for internal tracking and will range from 1 -20.
D (many pages)	Instructional symbols and information	These are instructional symbols on the form. The company may change the symbols at some point in time. The instructions are bracketed so that we may clarify or expand in the future if needed.
E (pages 12-14)	Notes	To allocate more or less space throughout for applicants to record information, we may increase or decrease the amount of space or number of pages.
F (pages 4, 5, 6)	#1. Life Insurance Plan, #1. Life Insurance Plan Information,	The products available for each category of insurance are bracketed in case the product names are changed, or if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.
G (page 7)	#1. Disability Income Insurance Plan – Insured's Occupation Class: and Disability Provision:	Bracketed in case the current Occupation Classes of 1A, 2A, 3A, 4A or 5A need to be revised and/or in case the product names are changed, if additional products are available or discontinued in the future. Any new products would be filed with your department, if required, for prior approval.
H (pages 4, 5, 6, 7)	#2. Riders/Options, #2. Riders, #2. Disability Income Insurance Riders	The riders available for each category of insurance are bracketed in the event the product or rider names are changed, increase percentage option is changed or added, or if riders are not offered for new issues of the policy or if additional products are available or discontinued in the future. Any new products or riders would be filed with your department, if required, for prior approval.
I (page 16)	State Fraud Notices	Bracketed in case additional state fraud warnings are added or if existing fraud notices are no longer required or are revised.
J (page 19)	TIN Certification	Bracketed for or possible changes to Federal TIN certification required language.
AR-COMP (page 20)	Advisor's Report Compensation options	The information may change as needed to identify the selling advisor, or to change or add advisor compensation options.
AR-SIGS (page 20)	Advisor's Report Signatures	The information may change as needed to verify replacement of coverage or add notes from the advisor, etc.

RiverSource Life Insurance Company
John Doe Specimen Packages for Application 134886

The four John Doe specimen types included are TERM, UL-VUL, SP-SS and VAR.

The sections unique to each product type are notated as follows:

Item (page #)	Section Name	Description
TERM (page 4)	Life Insurance Plan Information: Term Insurance	This entire section will print to the PDF file only when a Term Insurance product is being applied for by the applicant. See attached John Doe Specimen titled as "TERM".
UL-VUL (page 5)	Life Insurance Plan Information: Universal Life and Variable Universal Life	This entire section will print to the PDF file only when a Universal Life or Variable Universal Life product is being applied for by the applicant. See attached John Doe Specimen titled as "UL-VUL".
SP-SS (page 6)	Life Insurance Plan Information: Succession Protector and Succession Select	This entire section will print to the PDF file only when a Succession Protector or Succession Select product is being applied for by the applicant. See attached John Doe Specimen titled as "SP-SS".
VAR (page 6)	Variable Product Information	This entire section will print to the PDF file only when a variable product is being applied for by the applicant. No text changes would be made to the required variable language without prior filing for approval. See attached John Doe Specimens titled as "UL-VUL" and "SP-SS".
DI (pages 7, 8, 9)	Disability Income Plan Information Business Overhead Expense Protection Plan Information Disability Underwriting Information	These entire sections will print to the PDF file only when a Disability product being applied for by the applicant. See attached John Doe Specimen titled as "DI".
SP-SS 2nd (page 10)	Second Insured	This entire section will print to the PDF file only when Succession Protector or Succession Select products are being applied for by the applicant. See attached John Doe Specimen titled as "SP-SS".
SS-SP Rep (page 11)	Existing Life Insurance or Annuities (2 nd occurrence)	This second occurrence of the Replacement section will print to the PDF file only when Succession Protector or Succession Select products are being applied for by the applicant. See attached John Doe Specimen titled as "SP-SS".
UL-VUL-TERM (page 12)	Children's Insurance Rider	This entire section will print to the PDF file only when either a Universal Life or Variable Universal Life product or a Term Insurance product is being applied for by the applicant. See attached John Doe Specimens titled as "UL-VUL" and "TERM".
TERM-DI (page 15)	Credit or Charge Card Billing	This entire section will print to the PDF file only when either a Term Insurance product or Disability Insurance product is being applied for by the applicant. See attached John Doe Specimens titled as "TERM" and "DI".
CD-ROM (page 15)	#2. Consent for Delivery of Initial Prospectuses on CD-ROM	This entire section will print to the PDF file only when Universal Life, Variable Universal Life, Succession Protector or Succession Select products are being applied for by the applicant. See attached John Doe Specimens titled as "UL-VUL" and "SP-SS".
PROD-ACK (page 15)	Universal Life/Variable Universal Life/Succession Protector/Succession Select products	This entire section will print to the PDF file only when Universal Life, Variable Universal Life, Succession Protector or Succession Select products are being applied for by the applicant. It is a product acknowledgement related to benefits, values, surrender charges, guarantees and interest rates. See attached John Doe Specimens titled as "UL-VUL" and "SP-SS".



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application



Always complete Insured Information.

Reference Number	1234 1234567 1 001
Client ID	110000 0

INSURED INFORMATION

1. Insured:

Insured's Name (First, Middle Initial and Last Name) Male Female

John Q Doe

Insured's Phone Number (Day)

(612) 555-1234

Insured's Phone Number (Evening)

(612) 555-4321

Is Insured the Owner? Yes No If you answered "No" complete this page and Owner Information section.

Citizenship: U.S. Other: If Other, Insured is: Resident Alien Resident Alien with Green Card Nonresident Alien

Birth Date (MMDDYYYY) 05 02 1962 State of Birth or Country of Birth OH U.S. Social Security Number 123-45-6789

Driver's License (DL) Number 10000001 DL State of Issuance MN Occupation Insurance Underwriter

Employer Name RiverSource Insurance Individual Income \$ 50,000.00 Net Worth \$ 100,000.00 Household Income \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Dr. James Smith Date Last Seen (MMYYYY) 07 2011

Street Address 123 Main St City Edina State MN ZIP Code 55000 Phone (612) 555-1000

3. Premium Submitted:

Do not include any premium with this application if you:

- answered "Yes" to 2a or 2b above; or
- answered "Yes" to 2a or 2b in the Second Insured section (if Succession Protector or Succession Select product applied for); or
- are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$ 600.00

If one check is submitted for multiple products, please specify the dollar amount to each product.



⚠ Complete for disability income insurance products.

DISABILITY INCOME PLAN INFORMATION

1. Disability Income Insurance Plan Information

Base Monthly Benefit

\$ 5,000.00

Insured's Occupation Class:

1A 2A 3A 3M
 4A 4M 5A 5M

Waiting Period:

30 days 60 days 90 days
 180 days 365 days

Duration of Benefit: 1 year 3 year 5 years to age 65 to age 67

Premium Pattern: Level Step Rate

Disability Provision:

- | | |
|--|---|
| Occupation Classes 1A, 2A, 3A & 3M | <input type="radio"/> Income Protection Plus with 2 Years Occupation Protection (IPP-2) |
| Occupation Classes 4A, 4M, 5A & 5M | <input type="radio"/> Income Protection Plus with 5 Years Occupation Protection (IPP-5) |
| Occupation Classes 4A & 5A | <input checked="" type="radio"/> Income Protection Plus (IPP) |
| Occupation Classes 4A, 4M, 5A & 5M | <input type="radio"/> Income Protection with Residual Benefits (IPTr) |
| Occupation Classes 3A, 4A, 4M, 5A & 5M | <input type="radio"/> Income Protection (IPMod) |

Group Rate Options — Please indicate below ONLY if either of the following applies to this application.

- Employer Plan Coverage Unisex Rates Multiple Case Discount (See online reference materials for all qualification details.)

2. Disability Income Insurance Riders/Options

Social Benefits Rider \$ 1,000.00 per month with Waiting Period of 90 days

Supplemental Income Rider \$ _____ per month and benefit paid up through month _____
 with _____ day waiting period

Cost of Living Adjustment Maximum (classes 2A, 3A, 3M, 4A, 4M, 5A, and 5M)

Maximum: 3% 4% 5% 6% 7% 8% 9% 10%

Future Purchase Option \$ 5,000.00 Pool Amount

Other _____

3. Disability Income Insurance Premiums

Annual Premium \$ 600.00

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number _____

b. Special Payment Option SPO (Systematic Payout) Complete Form 200517

c. Direct Bill: Quarterly Semiannually Annually

d. Card Billing: MasterCard American Express Visa Discover

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number _____ Expires _____ Do not add security code.

e. Other _____



Complete for business overhead expense products.

BUSINESS OVERHEAD EXPENSE PROTECTION PLAN INFORMATION

1. Business Overhead Expense Protection Insurance Plan

(Cannot be applied for without personal disability income protection in force or applied for with RiverSource Life or other company.)

Complete Disability Underwriting Information section.

Monthly Benefit \$

Insured's Occupation Class: 3A 3M 4A 4M 5A 5M

Waiting Period: 30 days 60 days 90 days

Benefit Pattern: Level Increasing

Multiple DI Case Discount (See online reference materials for all qualification details.)

2. Business Overhead Expense Protection Insurance Premiums

Annual Premium \$

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number

b. Special Payment Option SPO (Systematic Payout) Complete Form 200517.

c. Direct Bill: Quarterly Semiannually Annually

d. Card Billing: MasterCard American Express Visa Discover

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number Expires Do not add security code.

e. Other

Complete for disability income and business overhead expense products.

DISABILITY UNDERWRITING INFORMATION

1. Are you currently actively employed? Yes No

a. If yes, number of hours per week Number of weeks per year

b. Self-employed? Yes No If yes:

i. Date business began (MMDDYYYY)

ii. Type of business or industry

- iii. Type of business entity: Sole Proprietorship
 S Corporation
 Partnership
 C Corporation
 Limited Liability Corporation
 Other

Disability Underwriting Information Continued on next page...



Disability Underwriting Information Continued

2. Occupational Duties

a. Provide a complete description of your job duties. Include a percentage of time spent on each task.

Review life and disability insurance applications 90%, meetings 10%

b. Do you manage or supervise others? Yes No

If yes, what percent of duties are supervisory? _____ % Number of employees _____

c. Provide any professional designations or educational degrees you hold which are specific to your occupation.

FLMI, FALU

3. Any contemplated change in occupation?

Yes No If yes, explain: _____

4. Previous occupation if changed in the past five years _____

5. Amount of unearned income \$ _____ **Source** _____

6. Is the Insured a member of a State, Public, or Federal Retirement System?

Yes No If yes, which one? _____

7. Is the Insured eligible for or does the insured have any disability income insurance through his/her employer?

a. Short-term: Yes No at \$ _____ per month for _____ months and _____ day waiting period

b. Long-term: Yes No at \$ _____ per month for _____ months and _____ day waiting period

c. If yes to b., is the group long-term disability integrated with Social Security? Yes No

d. Will the Insured's employer be paying the premiums for the RiverSource Life disability insurance? Yes No

e. Is the Insured eligible for benefits from a required state Cash Sickness disability program? Yes No

8. Existing Disability Income Insurance (all applicants must complete)

Insured: Do you have any other disability insurance currently in force or applied for? Yes No

If yes, you must complete all details in the grid below even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Insurance Amount/ Monthly Income	Being Replaced
Jefferson Insurance	10928374021	DI	1,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Monroe Mutual	09873214	DI	800.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Jackson Insurance	0987143	DI	1,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Inc.	8102394	BOE	10,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use the Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life disability policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.



NOTES

(Include details to any "Yes" answers or any additional replacement or other information.)

Disability Underwriting Information
Continued
8. Existing Disability Income Insurance
Taft Ltd - 10294387 - DI - Being Replaced? No



Review Disclosures and Notices below.

CREDIT OR CHARGE CARD BILLING AGREEMENT

(Not available for initial premium payment. Available with term and disability income insurance products only.)

- By signing for card billing, you authorize RiverSource Life Insurance Company to bill your card account for the insurance premiums and frequency indicated in the Plan Information sections applied for and you understand that payments will be automatically billed to your card account.
- You understand that RiverSource Life Insurance Company may receive updated card account information from your card company.
- You understand you may discontinue this payment at any time. The arrangement will remain in effect until you notify RiverSource Life Insurance Company in writing to cancel it, allowing reasonable time to act on your cancellation. Any such notification shall be effective only with respect to entries initiated after receipt of and reasonable time to act upon such notification, usually 15 days.
- RiverSource Life Insurance Company reserves the right to terminate this agreement at any time upon 30 days written notification.

STATE FRAUD NOTICES

For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

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

For Applicants in **District of Columbia** only:

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

For Applicants in **Kentucky** only:

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.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

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

For Applicants in **Oklahoma** only:

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

For Applicants in **Tennessee and Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)
X John Q Doe 09 15 2011

Second Insured's Signature
X _____

Owner's Signature (other than Insured)
X _____

Parent/Legal Guardian's Signature
(for Insureds under age 15)
X _____

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).
 Received from John Q Doe the sum of \$ 600.00 with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

Is Insured related to Advisor? Yes No If yes, give relationship. _____

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name	Advisor Number			
<input type="text" value="Ted Trustworthy"/>	<input type="text" value="1000000"/>			
Advisor's Signature	Date (MMDDYYYY)			
<input checked="" type="checkbox"/> <i>Ted Trustworthy</i> 09 15 2011	<input type="text" value="09 15 2011"/>			
Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text" value="01000"/>	<input type="text" value="100.00"/>	<input type="text" value="(612) 555-1000"/>	<input type="text"/>	<input type="text" value="91"/>

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Name	Advisor's Number
<input type="text"/>	<input type="text"/>

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name	Advisor Number			
<input type="text"/>	<input type="text"/>			
Advisor Signature	Date (MMDDYYYY)			
<input checked="" type="checkbox"/>	<input type="text"/>			
Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application Agreement and Signature

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Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

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If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Corporate Office Copy — Submit to Corporate Office

**Agreement and Signature Continued**

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)
X John Q Doe 09 15 2011

Second Insured's Signature
X _____

Owner's Signature (other than Insured)
X _____

Parent/Legal Guardian's Signature
 (for Insureds under age 15)
X _____

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).
 Received from John Q Doe the sum of \$ 600.00 with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- Radio buttons for options A (Upfront), B (Balanced), and C (Level).

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name: Ted Trustworthy; Advisor Number: 1000000

Advisor's Signature: X Ted Trustworthy 09 15 2011; Date (MMDDYYYY): 09 15 2011

Team ID: 01000; Comp %: 100.00; Phone: (612) 555-1000; Ext: ; Area Office Number: 91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Name: ; Advisor's Number: ;

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name: ; Advisor Number: ;

Advisor Signature: X; Date (MMDDYYYY): ;

Team ID: ; Comp %: ; Phone: ; Ext: ; Area Office Number: ;



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application



Always complete Insured Information.

Reference Number
1234 1234567 1 001

Client ID
10000001 2

INSURED INFORMATION

1. Insured:

Insured's Name (First, Middle Initial and Last Name) Male Female

John Q Doe

Insured's Phone Number (Day)
(612) 555-1234

Insured's Phone Number (Evening)
(612) 555-4321

Is Insured the Owner? Yes No If you answered "No" complete this page and Owner Information section.

Citizenship: U.S. Other: If Other, Insured is: Resident Alien
 Resident Alien with Green Card
 Nonresident Alien

Birth Date (MMDDYYYY) 05 02 1962 State of Birth or Country of Birth OH U.S. Social Security Number 123-45-6789

Driver's License (DL) Number 10000001 DL State of Issuance MN Occupation Insurance Underwriter

Employer Name RiverSource Insurance Individual Income \$ 50,000.00 Net Worth \$ 100,000.00 Household Income \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Dr. James Smith Date Last Seen (MMYYYY) 07 2001

Street Address 123 Main St City Edina State MN ZIP Code 55000 Phone (612) 555-1000

3. Premium Submitted:

Do not include any premium with this application if you:

- answered "Yes" to 2a or 2b above; or
- answered "Yes" to 2a or 2b in the Second Insured section (if Succession Protector or Succession Select product applied for); or
- are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$ 325.00

If one check is submitted for multiple products, please specify the dollar amount to each product.



! Complete all applicable sections.

OWNER INFORMATION (Complete if Owner is different from Insured as shown in the Insured Information section.)

Individual - Name (First, Middle Initial and Last Name)

U.S. Social Security Number _____ Birth Date (MMDDYYYY) _____

Male Female

Citizenship: U.S. Other: _____ If Other, Owner is: Resident Alien

Relationship to Insured _____ Resident Alien with Green Card

Nonresident Alien

Does the Owner wish to designate a Successor Owner? Yes No

If Yes, Successor Owner's Name _____ Relationship to Owner _____

Trust - Name of Trust _____

Revocable - Grantor's Taxpayer Identification Number (TIN) _____

Irrevocable - Trust's TIN _____

Name of Trustee _____ Date of Trust (MMDDYYYY) _____

Address of Trustee _____

City _____ State _____ ZIP Code _____

Business or Other Entity - Name _____

TIN _____ Relationship to Insured _____

Federal Tax Classification (if not an individual or trust, above.):

Sole Proprietor Partnership S-Corporation C-Corporation Estate

Limited Liability Company (LLC) (enter the tax classification: Partnership S-Corporation C-Corporation)

Other _____

Check here if Owner is an Exempt Payee (defined in IRS Form W-9 instructions)

BUSINESS INSURANCE (Complete if insurance is for business purposes.)

Type of Business Insurance: Buy/Sell Business Debt Protection Split Dollar Key Person

Executive Bonus/GEBA Deferred Compensation (nongovernmental)

Other _____



Complete all sections for life insurance products.

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No

If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	019874320	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	JK0198743	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	0198430 04132	whole Term	50,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10980431	Mortgage	88,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.

AGREEMENT TO SELL, TRANSFER OR ASSIGN LIFE INSURANCE

Any "party" to the application is defined as the insured, owner or any beneficiary. "Third Party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider or premium financing entity.

1. Agreements or Incentives — Has any Party to the application:

- Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
- Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the applied for policy; or
- Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the applied for policy? Yes No

2. Prior Transactions — Has any Party to the application ever:

- Sold, transferred or assigned any life insurance policy to a Third Party; or
- Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign any life insurance policy? Yes No

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.



Complete for Succession Protector and Succession Select products.

LIFE INSURANCE PLAN INFORMATION: Succession Protector and Succession Select

1. Life Insurance Plan Information Insured Amount \$ Purpose of Insurance

Succession Protector

Succession Select - **must select Option 1 or 2 for this plan:**

Death Benefit Option 1 (Level) Death Benefit Option 2 (Variable)

 Complete the Variable Product Information section AND Investment Option Allocation Form 33034 OR Portfolio Navigator Enrollment Form 402048.

Other

2. Riders/Options

Four Year Term of \$

Policy Split Option

Other

3. Life Insurance Premiums

Annual Scheduled Premium Lump-Sum Amount to Be Paid on Delivery of Policy

\$ \$

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number

b. Systematic Payment Option (SPO) (Complete Form 200517.)

c. Direct Bill: Quarterly Semiannually Annually

d. Other

4. Survivorship Beneficiary Designation

Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)

Complete for Variable Universal Life and Succession Select products.

VARIABLE PRODUCT INFORMATION

1. Variable Universal Life and Succession Select Information - Check each of the following below to indicate your acknowledgement: (Also, complete Investment Option Allocation Form 33034 or Portfolio Navigator Enrollment Form 402048.)

Adequate Information. You have received the current prospectuses for the policy applied for and any funds involved.

Purpose. You agree that this variable type of insurance is in accord with your insurance and financial objectives.

Variable values. You understand that the amount of Death Benefit and Policy Value can both increase and decrease; however, the Death Benefit will never be less than any Guaranteed Minimum Death Benefit.

Fees and Charges. The fees and charges have been explained to you and are also explained in detail in the policy.

2. Consent for Delivery of Initial Prospectuses on CD-ROM

Yes - By checking this box, I acknowledge that I have chosen to receive and have received the initial product and fund prospectuses on computer readable compact disk ("CD"). See details in Consent for Delivery of Initial Prospectus on CD-ROM section.



⚠ Complete for Succession Protector and Succession Select life insurance products.

SECOND INSURED

1. Second Insured:

Second Insured's Name (First, Middle Initial and Last Name) Male Female

Jane Q Doe

Second Insured's Phone Number (Day) Second Insured's Phone Number (Evening)

(612) 555-1234 (612) 555-4321

Citizenship: U.S Other: If Other, Second Insured is: Resident Alien
 Resident Alien with Green Card
 Nonresident Alien

Relationship to Insured

Wife

Birth Date (MMDDYYYY) State of Birth or Country of Birth U.S. Social Security Number
 07 15 1964 MN 234-56-7890

Driver's License (DL) Number DL State of Issuance Occupation
 120000002 MN Elementary Teacher

Employer Name Individual Income Net Worth Household Income
 Richfield ISD \$ 50,000.00 \$ 100,000.00 \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

a. In the past 12 months, has the Second Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No

b. In the past 12 months, has the Second Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No

c. Has the Second Insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
 05 1986

d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Date Last Seen (MMYYYY)
 Dr William Johnson 05 2011

Street Address City State ZIP Code Phone
 246 Oak St Edina MN 55000 (612) 444-2000



Complete for Succession Protector and Succession Select life insurance products.

EXISTING LIFE INSURANCE OR ANNUITIES

SECOND INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No
If marked Yes, you must complete all details in the grid below, even if the existing policy is not being replaced.
 If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	019874321	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	JK0198744	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	0198430 04133	whole Life	50,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10980431	Mortgage	88,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.

NOTES

(Include details to any "Yes" answers or any additional replacement or other information.)

EXISTING LIFE INSURANCE OR ANNUITIES
 (continued)
 INSURED:
 Washington Life - 77 777722 - whole Life - \$75,000 - Replace? No
 SECOND INSURED:
 Washington Life - 77 777733 - whole Life - \$50,000 - Replace? No

 LIFE INSURANCE PLAN INFORMATION: Succession Protector and Succession Select
 4. Survivorship Beneficiary Designation
 (continued)
 Testamentary Trustee(s) named in the Last will and Testament of the Insured, provided that such trustee(s) is(are) duly appointed pursuant to the probate of the will.



Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



●
Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



Review Disclosures and Notices below.

CONSENT FOR DELIVERY OF INITIAL PROSPECTUSES ON CD-ROM

I understand that I have the right to receive the prospectuses in paper format, which has been offered to me.

- I have access to and understand how to use the hardware and software that are necessary to view the prospectuses (see CD label for operating requirements).
- I understand that, in order to retain paper copies of the prospectuses, I must either:
 - A. Print the prospectuses found on the CD, incurring any printing costs myself; or
 - B. Request the prospectuses in paper form free of charge by calling Customer Service toll-free at 1(800) 333-3437.
- I understand that all future prospectus updates and supplements will be provided to me in paper form unless I sign up for online document delivery on the My Financial Accounts website at Ameriprise.com.

Universal Life/Variable Universal Life/Succession Protector/Succession Select products

If you have applied for this type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition, and the company's revenues and expenses.



STATE FRAUD NOTICES

For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

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

For Applicants in **District of Columbia** only:

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

For Applicants in **Kentucky** only:

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.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

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

For Applicants in **Oklahoma** only:

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

For Applicants in **Tennessee and Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)

X John Q Doe 09 15 2011

Second Insured's Signature

X Jane Q Doe

Owner's Signature (other than Insured)

X _____

Parent/Legal Guardian's Signature (for Insureds under age 15)

X _____

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from John Q Doe the sum of \$ 325.00 with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name	Advisor Number			
<input type="text" value="Ted Trustworthy"/>	<input type="text" value="1000000"/>			
Advisor's Signature	Date (MMDDYYYY)			
<input checked="" type="checkbox"/> <i>Ted Trustworthy 09 15 2011</i>	<input type="text" value="09 15 2011"/>			
Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text" value="01000"/>	<input type="text" value="100.00"/>	<input type="text" value="(612) 555-1000"/>	<input type="text"/>	<input type="text" value="91"/>

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.

Name	Advisor's Number
<input type="text"/>	<input type="text"/>

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name	Advisor Number			
<input type="text"/>	<input type="text"/>			
Advisor Signature	Date (MMDDYYYY)			
<input checked="" type="checkbox"/>	<input type="text"/>			
Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Corporate Office Copy — Submit to Corporate Office

**Agreement and Signature Continued**

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)		State	Signed on Date (MMDDYYYY)
John	Q Doe	MN	09 15 2011

Insured's Signature (base plan)

Second Insured's Signature

X John Q Doe 09 15 2011

X Jane Q Doe

Owner's Signature (other than Insured)

Parent/Legal Guardian's Signature
(for Insureds under age 15)

X _____

X _____

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from John Q Doe the sum of \$ 325.00 with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- Radio buttons for options A (Upfront), B (Balanced), and C (Level).

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name: Ted Trustworthy; Advisor Number: 1000000

Advisor's Signature: X Ted Trustworthy 09 15 2011; Date (MMDDYYYY): 09 15 2011

Team ID: 01000; Comp %: 100.00; Phone: (612) 555-1000; Ext: ; Area Office Number: 91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Name: ; Advisor's Number: ;

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name: ; Advisor Number: ;

Advisor Signature: X; Date (MMDDYYYY): ;

Team ID: ; Comp %: ; Phone: ; Ext: ; Area Office Number: ;

● **TERM**
John Doe Specimen



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application



Always complete Insured Information.

Reference Number	1234 1234567 1 001
Client ID	10000000 0

INSURED INFORMATION

1. Insured:

Insured's Name (First, Middle Initial and Last Name) Male Female
John Q Doe

Insured's Phone Number (Day) (612) 555-1234 Insured's Phone Number (Evening) (612) 555-4321

Is Insured the Owner? Yes No If you answered "No" complete this page and Owner Information section.

Citizenship: U.S. Other: If Other, Insured is: Resident Alien
 Resident Alien with Green Card
 Nonresident Alien

Birth Date (MMDDYYYY) 05 02 1962 State of Birth or Country of Birth OH U.S. Social Security Number 123-45-6789

Driver's License (DL) Number 10000001 DL State of Issuance MN Occupation Insurance Underwriter

Employer Name RiverSource Insurance Individual Income \$ 50,000.00 Net Worth \$ 100,000.00 Household Income \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Dr. James Smith Date Last Seen (MMYYYY) 07 2011

Street Address 123 Main St City Edina State MN ZIP Code 55000 Phone (612) 555-1000

3. Premium Submitted:

- Do not include any premium with this application if you:
- answered "Yes" to 2a or 2b above; or
 - answered "Yes" to 2a or 2b in the Second Insured section (if Succession Protector or Succession Select product applied for); or
 - are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$ 1,200.00

If one check is submitted for multiple products, please specify the dollar amount to each product.



! Complete all applicable sections.

OWNER INFORMATION (Complete if Owner is different from Insured as shown in the Insured Information section.)

Individual - Name (First, Middle Initial and Last Name)

U.S. Social Security Number _____ Birth Date (MMDDYYYY) _____

Male Female

Citizenship: U.S. Other: _____ If Other, Owner is: Resident Alien

Relationship to Insured _____ Resident Alien with Green Card Nonresident Alien

Does the Owner wish to designate a Successor Owner? Yes No

If Yes, Successor Owner's Name _____ Relationship to Owner _____

Trust - Name of Trust

Revocable - Grantor's Taxpayer Identification Number (TIN) _____

Irrevocable - Trust's TIN _____

Name of Trustee _____ Date of Trust (MMDDYYYY) _____

Address of Trustee _____

City _____ State _____ ZIP Code _____

Business or Other Entity - Name

TIN _____ Relationship to Insured _____

Federal Tax Classification (if not an individual or trust, above.):

Sole Proprietor Partnership S-Corporation C-Corporation Estate

Limited Liability Company (LLC) (enter the tax classification: Partnership S-Corporation C-Corporation)

Other _____

Check here if Owner is an Exempt Payee (defined in IRS Form W-9 instructions)

BUSINESS INSURANCE (Complete if insurance is for business purposes.)

Type of Business Insurance: Buy/Sell Business Debt Protection Split Dollar Key Person

Executive Bonus/GEBA Deferred Compensation (nongovernmental)

Other _____



Complete all sections for life insurance products.

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No

If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	019874320	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	JK0198743	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	0198430 04132	whole Life	50,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10980431	Mortgage	88,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.

AGREEMENT TO SELL, TRANSFER OR ASSIGN LIFE INSURANCE

Any "party" to the application is defined as the insured, owner or any beneficiary. "Third Party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider or premium financing entity.

1. Agreements or Incentives — Has any Party to the application:

- Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
- Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the applied for policy; or
- Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the applied for policy? Yes No

2. Prior Transactions — Has any Party to the application ever:

- Sold, transferred or assigned any life insurance policy to a Third Party; or
- Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign any life insurance policy? Yes No

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.



Complete for term life insurance products.

LIFE INSURANCE PLAN INFORMATION: Term Life Insurance

1. Life Insurance Plan Information

a. Level Term Plans: 20-Year 15-Year 10-Year

Insured Amount \$ 500,000.00

b. Income Protection Life Plans: Term to Age 60 Term to Age 65 Term to Age 67

Monthly Death Benefit Amount is \$

c. Other Insured Amount \$

2. Riders/Options

Level Term

Waiver of Premium

Accidental Death Benefit of \$

Children's Insurance Rider (CIR) Units Provide details in CIR section.

Income Protection Life

Waiver of Premium

Cost of Living Adjustment

Other

3. Life Insurance Premiums

Annual Premium

\$ 1,200.00

a. Bank Authorization (BA): Monthly Quarterly

New BA Authorization (Complete Form 200517.)

Add to Existing BA with Account Number

b. Systematic Payment Option (SPO) (Complete Form 200517.)

c. Direct Bill: Quarterly Semiannually Annually

d. Card Billing: MasterCard American Express Visa Discover

Frequency (not available for initial payment): Monthly Quarterly Semiannually Annually

Card Number Expires Do not add security code.

e. Other:

4. Life Insurance Beneficiary — Term Insurance

Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.

Insured's Spouse's Full Name

Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.

Insured's Spouse's Full Name

Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)

Jane Doe, Spouse, if living; if not, Terrence Doe, Brother, 50%, Justin Johnson Doe, Son, 25%, and Anne Marie Doe, Daughter, the survivors proportionately, or the survivor. If none survive, the



- Complete Children's Insurance Rider section if CIR is applied for.
- Complete the Notes section for additional information for all products.

CHILDREN'S INSURANCE RIDER INFORMATION

1. Name(s) of child(ren) to be covered by rider (must be under age 19 and unmarried):

Name (First, Full Middle, Last)	Birth Date (MMDDYYYY)	Sex	Physical/Mental Abnormalities at Birth?
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No

2. Has anyone listed above received treatment for any disease, physical or mental condition in the past five years?

Yes No

3. Is this insurance intended to replace any existing insurance and/or annuity? Yes No

4. If "Yes" was checked for 1, 2 or 3 above, explain here:

5. Are there any children under the age of 19 and unmarried not listed above? Yes No

If "Yes" list name:

Birth Date (MMDDYYYY)

Reason for exclusion

NOTES

(Include details to any "Yes" answers or any additional replacement or other information.)

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED:

(continued)

Washington Life - 77 777722 - whole Life - \$75,000 - \$0.00 - Replace? no

LIFE INSURANCE PLAN INFORMATION: Term Life Insurance

4. Life Insurance Beneficiary – Term Insurance

Option C

(continued)

Testamentary Trustee(s) named in the Last will and Testament of the Insured, provided that such trustee(s) is(are) duly appointed pursuant to the probate of the will.



Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



Review Disclosures and Notices below.

CREDIT OR CHARGE CARD BILLING AGREEMENT

(Not available for initial premium payment. Available with term and disability income insurance products only.)

- By signing for card billing, you authorize RiverSource Life Insurance Company to bill your card account for the insurance premiums and frequency indicated in the Plan Information sections applied for and you understand that payments will be automatically billed to your card account.
- You understand that RiverSource Life Insurance Company may receive updated card account information from your card company.
- You understand you may discontinue this payment at any time. The arrangement will remain in effect until you notify RiverSource Life Insurance Company in writing to cancel it, allowing reasonable time to act on your cancellation. Any such notification shall be effective only with respect to entries initiated after receipt of and reasonable time to act upon such notification, usually 15 days.
- RiverSource Life Insurance Company reserves the right to terminate this agreement at any time upon 30 days written notification.

STATE FRAUD NOTICES

For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

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

For Applicants in **District of Columbia** only:

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

For Applicants in **Kentucky** only:

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.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

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

For Applicants in **Oklahoma** only:

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

For Applicants in **Tennessee and Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

●

Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)
X John Q Doe 09 15 2011

Second Insured's Signature
X

Owner's Signature (other than Insured)
X

Parent/Legal Guardian's Signature (for Insureds under age 15)
X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).
Received from John Q Doe the sum of \$ 1,200.00 with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

Is Insured related to Advisor? Yes No If yes, give relationship. _____

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name Advisor Number

Advisor's Signature *Ted Trustworthy* 09 15 2011 Date (MMDDYYYY)

Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text" value="01000"/>	<input type="text" value="100"/>	<input type="text" value="612-555-24"/>	<input type="text"/>	<input type="text" value="91"/>

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

i If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.
Name Advisor's Number

w It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name Advisor Number

Advisor Signature *X* Date (MMDDYYYY)

Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text"/>				



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Corporate Office Copy — Submit to Corporate Office

**Agreement and Signature Continued**

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)

Second Insured's Signature

X John Q Doe 09 15 2011

X

Owner's Signature (other than Insured)

Parent/Legal Guardian's Signature
(for Insureds under age 15)

X

X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from John Q Doe the sum of \$ 1,200.00 with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- Radio buttons for options A (Upfront), B (Balanced), and C (Level).

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name Ted Trustworthy Advisor Number 1000000

Advisor's Signature X Ted Trustworthy 09 15 2011 Date (MMDDYYYY) 09 15 2011

Team ID 01000 Comp % 100.00 Phone (612) 555-2424 Ext Area Office Number 91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Name Advisor's Number

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name Advisor Number

Advisor Signature Date (MMDDYYYY)

Team ID Comp % Phone Ext Area Office Number



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application



Always complete Insured Information.

Reference Number	1234 1234567 1 001
Client ID	10000000 0

INSURED INFORMATION

1. Insured:

Insured's Name (First, Middle Initial and Last Name) Male Female

John Q Doe

Insured's Phone Number (Day) Insured's Phone Number (Evening)

(612) 555-1234 (612) 555-4321

Is Insured the Owner? Yes No If you answered "No" complete this page and Owner Information section.

Citizenship: U.S. Other: If Other, Insured is: Resident Alien Resident Alien with Green Card Nonresident Alien

Birth Date (MMDDYYYY) State of Birth or Country of Birth U.S. Social Security Number
05 02 1962 OH 123-45-6789

Driver's License (DL) Number DL State of Issuance Occupation
10000001 MN Insurance Underwriter

Employer Name Individual Income Net Worth Household Income
RiverSource Insurance \$ 50,000.00 \$ 100,000.00 \$ 100,000.00

2. Coverage Questions:

IT IS IMPORTANT THAT ANSWERS ARE TRUE, ACCURATE AND COMPLETE. ANY UNTRUE, INACCURATE OR INCOMPLETE INFORMATION COULD AFFECT YOUR INSURANCE COVERAGE.

- a. In the past 12 months, has the Insured been hospitalized, placed in hospice care, or been advised by a health care professional to be hospitalized or placed in hospice care on either an inpatient or outpatient basis for any reason other than normal pregnancy? Yes No
- b. In the past 12 months, has the Insured received treatment or advice from a health care professional for heart disease, chest pain, stroke, cancer (except basal cell carcinoma), kidney failure, liver failure or unexplained weight loss? Yes No
- c. Has the insured ever used tobacco or nicotine in any form? Yes No Date of Last Use (MMYYYY)
- d. Personal Physician or Primary Care Provider (Check here if none.)

Doctor or Clinic Name Date Last Seen (MMYYYY)
Dr. James Smith 09 2011

Street Address City State ZIP Code Phone
123 Main St Edina MN 55000 (612) 555-1000

3. Premium Submitted:

Do not include any premium with this application if you:

- answered "Yes" to 2a or 2b above; or
- answered "Yes" to 2a or 2b in the Second Insured section (if Succession Protector or Succession Select product applied for); or
- are applying for death benefits totaling over \$1,000,000.

No money paid with this application Money paid with this application \$ 2,400.00

If one check is submitted for multiple products, please specify the dollar amount to each product.



! Complete all applicable sections.

JUVENILE INSURANCE (Complete if insured is under age 15.)

Is there similar insurance in force or applied for on all siblings? Yes No If no, why?

Amount of life insurance already in force on the person responsible for child's primary support \$

OWNER INFORMATION (Complete if Owner is different from Insured as shown in the Insured Information section.)

Individual - Name (First, Middle Initial and Last Name)

U.S. Social Security Number Birth Date (MMDDYYYY)

Male Female

Citizenship: U.S. Other:

If Other, Owner is:

- Resident Alien
- Resident Alien with Green Card
- Nonresident Alien

Relationship to Insured

Does the Owner wish to designate a Successor Owner? Yes No

If Yes, Successor Owner's Name

Relationship to Owner

Trust - Name of Trust

Revocable - Grantor's Taxpayer Identification Number (TIN)

Irrevocable - Trust's TIN

Name of Trustee

Date of Trust (MMDDYYYY)

Address of Trustee

City

State

ZIP Code

Business or Other Entity - Name

TIN

Relationship to Insured

Federal Tax Classification (if not an individual or trust, above.):

- Sole Proprietor Partnership S-Corporation C-Corporation Estate
- Limited Liability Company (LLC) (enter the tax classification: Partnership S-Corporation C-Corporation)
- Other

Check here if Owner is an Exempt Payee (defined in IRS Form W-9 instructions)

BUSINESS INSURANCE (Complete if insurance is for business purposes.)

Type of Business Insurance: Buy/Sell Business Debt Protection Split Dollar Key Person
 Executive Bonus/GEBA Deferred Compensation (nongovernmental)
 Other



Complete all sections for life insurance products.

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED: Do you have any other **annuities** or **life insurance** currently in force or applied for? Yes No

If marked **Yes**, you must complete all details in the grid below, even if the existing policy is not being replaced. If a policy will be replaced, all state specific replacement forms must be completed.

Company	Policy Number	Type	Amount	Being Replaced
ABC Insurance	GJ 109823740	VUL	100,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
BCD Mutual	098170124	Term	100,000.00	<input checked="" type="radio"/> Yes <input type="radio"/> No
Adams Insurance	09218743 23	Whole Life	25,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No
Jefferson Security	10324adfa2	Mortgage	80,000.00	<input type="radio"/> Yes <input checked="" type="radio"/> No

Use Notes section if you have additional insurance coverage information to document.

You must check "Yes" to "Being Replaced" if:

- There is any possibility that the new RiverSource Life Insurance Company (RiverSource Life) policy will replace another policy, even if it is not yet certain.
- Premium payments will be discontinued on an existing policy or if the existing policy is surrendered, reduced, annuitized or otherwise terminated, in part or in full.
- A policy has been applied for with another company and that policy is not or will not be accepted.

Important Notice: In some states you must submit the "Important Notice: Replacement of Life Insurance or Annuities" (Form 200084) whenever the client has existing insurance or annuities, **even if there is no replacement involved.**

Life External Replacements: If a 1035 Exchange to the RiverSource Life policy will be requested, the 1035 Exchange Request (Form 30062) must also be completed.

Life Internal Replacements: If "Being Replaced" is checked "Yes" and you are replacing a RiverSource Life policy, by signing this application, the existing RiverSource Life policy(s) listed above will be surrendered upon underwriting approval unless you inform us otherwise.

The cash value should be: applied to the new RiverSource Life policy, or returned to the owner.

AGREEMENT TO SELL, TRANSFER OR ASSIGN LIFE INSURANCE

Any "party" to the application is defined as the insured, owner or any beneficiary. "Third Party" is defined as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider or premium financing entity.

1. Agreements or Incentives — Has any Party to the application:

- Entered, or made plans to enter, into any agreement or contract to sell or assign the ownership of, or a beneficial interest in, the applied for policy; or
- Been promised or agreed to by any person that they will be given, or have been given, any inducement, fee or compensation as an incentive to purchase the applied for policy; or
- Received, or will receive, from any person any inducement, fee or compensation as incentive to purchase the applied for policy? Yes No

2. Prior Transactions — Has any Party to the application ever:

- Sold, transferred or assigned any life insurance policy to a Third Party; or
- Received any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign any life insurance policy? Yes No

For any "Yes" responses to 1 or 2 above, provide details regarding any agreements, incentives or prior transactions.



! Complete for universal life and variable universal life insurance products.

LIFE INSURANCE PLAN INFORMATION: Universal Life and Variable Universal Life

1. Life Insurance Plan Information Insured Amount \$ 500,000.00 Purpose of Insurance Income Replacement

- Foundations Protector (FP)
- Foundations Universal Life (FUL): Death Benefit Option: 1 (Level) 2 (Variable)
Life Insurance Qualification Test: Guideline Premium Test Cash Value Accumulation Test
(If nothing is chosen, default is Guideline Premium Test.)
- Indexed Universal Life (IUL): Death Benefit Option: 1 (Level) 2 (Variable)
Life Insurance Qualification Test: Guideline Premium Test Cash Value Accumulation Test
(If nothing is chosen, default is Guideline Premium Test.)
Premium Allocation: Fixed Account _____ % Indexed Account _____ %
(Total must equal 100%. If no percentage indicated, default is Fixed Account 100% and Indexed Account 0%.)
Segment Maturity Reallocation: Fixed Account _____ % Indexed Account _____ %
(Total must equal 100%. If no percentage indicated, default is Fixed Account 0% and Indexed Account 100%.)
- Variable Universal Life (VUL): Death Benefit Option: 1 (Level) 2 (Variable)
Complete the Variable Product Information section AND Investment Option Allocation Form 33034 OR Portfolio Navigator Enrollment Form 402048.
- Other _____

2. Riders/Options

- Accelerated Benefit Rider for Terminal Illness
- AdvanceSource* Rider - Complete *AdvanceSource* Rider application.
- Waiver of Monthly Deduction (FUL, IUL, VUL only)
- Waiver of Specified Premium - Monthly Specified Premium \$ _____ (FUL, IUL, VUL only)
- Accidental Death Benefit of \$ _____ (FUL, IUL and VUL only)
- Children's Insurance Rider (CIR) Units _____ (FUL, IUL, VUL only) Provide details in the CIR section.
- Automatic Increase Benefit Rider: (FUL, IUL, VUL only) 2% 3% 4% 5% 6% 7% 8%
- Other _____

3. Life Insurance Premiums

Annual Scheduled Premium Lump-Sum Amount to Be Paid on Delivery of Policy
\$ 2,400.00 \$ _____

- a. Bank Authorization (BA): Monthly Quarterly
 New BA Authorization (Complete Form 200517.)
 Add to Existing BA with Account Number _____
- b. Systematic Payment Option (SPO) (Complete Form 200517.)
- c. Direct Bill: Quarterly Semiannually Annually
- d. Other _____

4. Life Insurance Beneficiary - Universal Life and Variable Universal Life

- Option A: Beneficiary is: Insured's designated spouse, if living, otherwise the beneficiaries are the living lawful children of the insured and they will receive equal shares of the proceeds.
Insured's Spouse's Full Name _____
- Option B: Beneficiary is: Insured's designated spouse, if living, otherwise, the beneficiaries are the lawful children of the insured and they will receive equal shares of the proceeds; provided, however, that if a child of the insured has died before the insured, the share which the child would have received if he/she survived the insured will be paid to his/her living lawful children in equal shares.
Insured's Spouse's Full Name _____
- Option C: Other Designation: Name and relationship to the insured (and percentage each beneficiary will receive, if applicable)
Jane Doe, Spouse, if living; if not, Terrence Doe, Brother, 50%, Justin Johnson Doe, Son, 25%, and Anne Marie Doe, Daughter, the survivors



Complete for Variable Universal Life and Succession Select products.

VARIABLE PRODUCT INFORMATION

1. **Variable Universal Life and Succession Select Information - Check each of the following below to indicate your acknowledgement:** (Also, complete Investment Option Allocation Form 33034 or Portfolio Navigator Enrollment Form 402048.)
 - Adequate Information.** You have received the current prospectuses for the policy applied for and any funds involved.
 - Purpose.** You agree that this variable type of insurance is in accord with your insurance and financial objectives.
 - Variable values.** You understand that the amount of Death Benefit and Policy Value can both increase and decrease; however, the Death Benefit will never be less than any Guaranteed Minimum Death Benefit.
 - Fees and Charges.** The fees and charges have been explained to you and are also explained in detail in the policy.
2. **Consent for Delivery of Initial Prospectuses on CD-ROM**
 - Yes - By checking this box, I acknowledge that I have chosen to receive and have received the initial product and fund prospectuses on computer readable compact disk ("CD"). See details in Consent for Delivery of Initial Prospectus on CD-ROM section.



- Complete Children's Insurance Rider section if CIR is applied for.
- Complete the Notes section for additional information for all products.

CHILDREN'S INSURANCE RIDER INFORMATION

1. Name(s) of child(ren) to be covered by rider (must be under age 19 and unmarried):

Name (First, Full Middle, Last)	Birth Date (MMDDYYYY)	Sex	Physical/Mental Abnormalities at Birth?
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Yes <input type="radio"/> No

2. Has anyone listed above received treatment for any disease, physical or mental condition in the past five years?

Yes No

3. Is this insurance intended to replace any existing insurance and/or annuity? Yes No

4. If "Yes" was checked for 1, 2 or 3 above, explain here:

5. Are there any children under the age of 19 and unmarried not listed above? Yes No

If "Yes" list name:

Birth Date (MMDDYYYY)

Reason for exclusion

NOTES

(Include details to any "Yes" answers or any additional replacement or other information.)

EXISTING LIFE INSURANCE OR ANNUITIES

INSURED:

(continued)

Washington Life - 77 777722 - whole Life - \$75,000 - \$0.00 - Replace? no

LIFE INSURANCE PLAN INFORMATION: Universal Life and Variable Universal Life

4. Life Insurance Beneficiary - Universal Life and Variable Universal Life

Option C

(continued)

proportionately, or the survivor. If none survive, the Testamentary Trustee(s) named in the Last will and Testament of the Insured, provided that such trustee(s) is(are) duly appointed pursuant to the probate of the will.



Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



Notes Continued

(Include details to any "Yes" answers or any additional replacement or other information.)



 Review Disclosures and Notices below.

CONSENT FOR DELIVERY OF INITIAL PROSPECTUSES ON CD-ROM

- I understand that I have the right to receive the prospectuses in paper format, which has been offered to me.
- I have access to and understand how to use the hardware and software that are necessary to view the prospectuses (see CD label for operating requirements).
 - I understand that, in order to retain paper copies of the prospectuses, I must either:
 - A. Print the prospectuses found on the CD, incurring any printing costs myself; or
 - B. Request the prospectuses in paper form free of charge by calling Customer Service toll-free at 1(800) 333-3437.
 - I understand that all future prospectus updates and supplements will be provided to me in paper form unless I sign up for online document delivery on the My Financial Accounts website at Ameriprise.com.

Universal Life/Variable Universal Life/Succession Protector/Succession Select products

If you have applied for this type of insurance, you understand and acknowledge that (1) a projection of future death benefits and policy values will be provided upon written request; (2) surrender charges may apply in certain circumstances; (3) no-lapse guarantee or death benefit guarantee features as applicable to the type of insurance applied for have been adequately described to you and may involve premium in excess of your scheduled premium; and (4) interest at rates in excess of the guaranteed interest rate will accrue on any policy value/fixed account value at rates determined by the company and at the company's discretion. These rates will be based on various factors including, but not limited to, the interest rate environment, returns earned on investments backing these policies, the rates currently in effect for new and existing company policies, product design, competition, and the company's revenues and expenses.



STATE FRAUD NOTICES

For Applicants in **Arkansas, Louisiana and Rhode Island** only:

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

For Applicants in **Colorado** only:

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

For Applicants in **District of Columbia** only:

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

For Applicants in **Kentucky** only:

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.

For Applicants in **New Mexico** only:

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

For Applicants in **Ohio** only:

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

For Applicants in **Oklahoma** only:

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

For Applicants in **Tennessee and Washington** only:

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

For Applicants in **Texas** only:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

●

Agreement and Signature Continued

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)	State	Signed on Date (MMDDYYYY)
John Q Doe	MN	09 15 2011

Insured's Signature (base plan)
X *John Q Doe* 09 15 2011

Second Insured's Signature
X

Owner's Signature (other than Insured)
X

Parent/Legal Guardian's Signature (for Insureds under age 15)
X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).
Received from John Q Doe the sum of \$ 2,400.00 with this application.

Agreement and Signature Continued on next page...

Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
- B (Balanced)
- C (Level)

Is Insured related to Advisor? Yes No If yes, give relationship. _____

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name Advisor Number

Advisor's Signature *Ted Trustworthy* 09 15 2011 Date (MMDDYYYY)

Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text" value="01000"/>	<input type="text" value="100%"/>	<input type="text" value="(612) 555-1000"/>	<input type="text"/>	<input type="text" value="91"/>

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above.
Name Advisor's Number

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name Advisor Number

Advisor Signature _____ Date (MMDDYYYY)

Team ID	Comp %	Phone	Ext	Area Office Number
<input type="text"/>				



RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474

Life and Disability Income Insurance Application Agreement and Signature

Agreement: By signing this application, you acknowledge that you understand and agree with all of the following terms, conditions and disclosures applicable to the product applied for. You also understand this document may contain disclosures pertaining to products not applied for.

Identification and Verification: We are required by law to obtain certain personal information from you that will be used by us to verify your identity. If you do not provide us with the information, we may not be able to issue you a policy or rider. If we are unable to verify your identity, we reserve the right to withdraw your application, rescind your policy and/or rider or take such other steps as we deem reasonable.

Conditional Insurance Coverage Prior to Policy Delivery: You agree that an Insured for life or disability insurance will be covered prior to policy delivery only when all of the following requirements have been met:

- The owner has paid the full first premium, according to the frequency of modal premium payment selected, for all insurance applied for in this application (any check or draft for that payment must be honored by the bank); and
- The premium has not been returned by the company; and
- The Insured has submitted all medical and other information required by the company's written underwriting rules; and
- The Insured is insurable on the Effective Date, as defined below, under the company's written underwriting rules, for the plan of insurance and amount of insurance at the premium rate applied for with no modification. "Effective Date" as used herein means the later of: (a) the date of this application; or (b) the date of completion of the company's paramedical/medical examinations, the company's medical information gathering interview; and any other information as required by the company's written underwriting rules.

In cases where the Insured is not insurable for the plan of insurance, amount of insurance, or at the premium rate applied for, coverage begins if and when the company insures that person under a policy accepted by the owner in writing and any additional premium has been paid. For disability coverage, all disability policies specified to be discontinued in this application must also be discontinued before coverage will begin; (this limitation is subject to the incontestability provision in the policy.)

Amount of Life Insurance Coverage: If coverage begins prior to delivery of the policy under the conditions described above and death of an Insured occurs prior to delivery of the policy, the amount of life insurance coverage on each Insured will be the total requested for that person by this application and any other applications for life insurance on the Insured being considered by the company, up to a maximum of \$500,000. Except as limited by this agreement, any coverage provided will be under the terms of the policy or rider applied for.

Amount of Disability Insurance Coverage: If conditional coverage begins prior to delivery of the policy under the conditions described above and a disability of the Insured begins prior to delivery of the policy, the disability coverage monthly benefit on the Insured will be the lesser of (1) \$3,500 of monthly benefit, (2) the monthly benefit applied for in this application, or (3) the maximum monthly benefit based on the company's written underwriting rules. Coverage on the Insured for this monthly benefit will be provided under the terms of the policy or rider until the first of the following to occur: (1) benefits paid and payable total \$500,000 or (2) the Insured is no longer eligible for benefits under the terms of the policy or rider because the Insured is no longer disabled or the maximum benefit period has been reached. When the first of (1) or (2) occur, all benefits will cease and coverage under this agreement and the policy will cease.

Company's Responsibilities: You understand that:

Only the officers of the company have the authority to decide on insurability and risk classification and to bind the company to insure a proposed Insured. The officers of the company are the President, Vice President, Secretary and Assistant Secretary;

If a policy does not go into effect, the company's sole liability will be to refund any premium paid, plus interest if required by law;

No change in or waiver of anything in this application or alteration of an insurance policy or rider is binding unless it is in writing and signed by an officer of the company; and

By accepting a policy, the owner ratifies any changes to this application entered at any time on the Home Office Endorsement form attached to the policy (*not applicable in Maryland, Missouri, New Hampshire, New Jersey, Pennsylvania and West Virginia*). However, the owner must sign a separate written document for any change in type of plan, amount, benefits or Insured's risk classification.

Any insurance provided by this agreement will be subject to the conditions and terms of the policy applied for.

Agreement and Signature Continued on next page...

Corporate Office Copy — Submit to Corporate Office

**Agreement and Signature Continued**

Qualified Plans Only: You certify that the Owner is qualified under Section 401(a) of the United States Internal Revenue Code. This policy or rider will be issued based on representations by you that the Plan is qualified.

Adequate Information: You have received the RiverSource Life Insurance Company (RiverSource Life) Insurance Products Disclosure. You understand and agree that the company will use and release information about you as described in the RiverSource Life Insurance Products Disclosure. You may inform us not to use information for certain marketing purposes described in the RiverSource Life Insurance Products Disclosure.

Electronic Signature: The application and other documents may be signed using an electronic signature. To sign the application today you may use an electronic signature pad to provide your electronic signature. To sign your application from home, you may log onto your My Financial Accounts account. The medical portion of your application will be completed via telephone interview. At the end of the interview you will have the opportunity to provide your verbal consent to sign the medical portion of your application using an electronic voice signature. Upon providing your electronic voice signature, the information gathered during the telephone interview will become part of your insurance application and will be subject to the terms of the Declaration section below. You may stop the application process at any time during the telephone interview.

If you choose not to utilize an electronic signature to sign the application, including the medical portion, we will contact you to obtain a written signature. You may obtain a non-electronic version of any applicable electronic documents by sending a signed written request containing your full name and date of birth to: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Attention Insurance Underwriting, Minneapolis, MN 55474.

Declaration: You declare that all answers provided are true, accurate and complete; and you understand that all your answers will be a basis for our underwriting analysis for any policy and/or rider issued and that any untrue, inaccurate or incomplete information could result in the denial of any claims made and/or the rescission of any policy and/or rider issued. You also acknowledge that you have received a copy of this agreement, the Disability Income and Business Overhead Expense outline of coverage (if applicable) and receipt for any premium paid with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Authorization and Certification

By your signature below, the owner authorizes MIB, Inc., the employer, and consumer reporting agency having information about you and your minor children to give that information to RiverSource Life or its reinsurer. You understand that you have the right to request a personal interview if an investigative consumer report is obtained. You understand that RiverSource Life will use this information to determine eligibility for insurance and benefits. You agree that a photographic copy of this authorization will be as valid as the original, and that this authorization will be valid for 30 months from the date shown below (24 months in CT, KY, ND, NM, OK, WV and WY).

W-9 Certification:

As used below, the word "I" refers to the applicant who is the taxpayer on the policy.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, 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 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 below).

Certification Instructions: check this box 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.

Definition of a U.S. Person. For federal tax purposes, you are considered a U.S. Person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Non-U.S. persons submit the appropriate Form W-8. Form W-9 and Form W-8 and their instructions are available upon request or on irs.gov.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

You acknowledge that you or your authorized representative have received a copy of this agreement and signature section of the application.

Signatures (Insureds under age 15 need not sign.)

Insured's Name (Print)		State	Signed on Date (MMDDYYYY)
John	Q Doe	MN	09 15 2011

Insured's Signature (base plan)

X *John Q Doe* 09 15 2011

Second Insured's Signature

X

Owner's Signature (other than Insured)

X

Parent/Legal Guardian's Signature
(for Insureds under age 15)

X

Receipt — All checks must be completed in full and be made payable to the company (not to the advisor).

Received from John Q Doe the sum of \$ 2,400.00 with this application.

Agreement and Signature Continued on next page...



Agreement and Signature Continued

Advisor's Report

Compensation options for Foundations UL, Indexed UL and VUL products only: If no option is chosen, default is option A. Once chosen and submitted, the compensation choice cannot be changed. Not all options may be available for all products or riders.

- A (Upfront)
B (Balanced)
C (Level)

Is Insured related to Advisor? Yes No If yes, give relationship.

You certify that you personally requested the information in this application and that you truly and accurately recorded on the application the information supplied by the applicant. You are not aware of anything detrimental to the risk that is not recorded in this application. You certify that, to the best of your knowledge and belief, the information provided in this application regarding replacement of existing insurance and annuities is true and accurate.

Advisor's Name Ted Trustworthy Advisor Number 1000000

Advisor's Signature X Ted Trustworthy 09 15 2011 Date (MMDDYYYY) 09 15 2011

Team ID 01000 Comp % 100.00 Phone (612) 555-1000 Ext Area Office Number 91

Recommending Advisor Information

Is this transaction based on a recommendation by an Ameriprise Financial Advisor? Yes No

If yes, provide the Recommending Advisor Name and ID below if different than Advisor listed above. Name Advisor's Number

It is assumed the Recommending Advisor and Advisor listed above are the same, if the Recommending Advisor is not identified.

Co-Advisor Information

Name Advisor Number

Advisor Signature X Date (MMDDYYYY)

Team ID Comp % Phone Ext Area Office Number

RiverSource Life Insurance Company
Statement of Variability
Form 131244 Electronic Signature

Dated: 10/10/2011

State of: Arkansas

Brackets have been placed around various items in the forms in order to indicate that they are variable and subject to change by us as explained below.

- Formatting may change due to future changes in typestyle and/or electronic generation of the forms. However, any adaptation we make will not involve changes to text without any necessary prior approval and will always meet or exceed the requirements of your state.
- We reserve the right to correct typographical errors.

Item No.	Field	Scope of Variation
1	Bar Code and identifier number.	The spacing, typestyle and ink color appearance may change. Or use of the bar code may be discontinued as an identifier.
2	Address	Will insert the current company home office address.
3	List of forms in Document Packet	<p>The specific document names will populate unique to each product, client and applicable state. Additional forms or revised form names may also be included in the future. When applicable, any or all of the following forms will be listed:</p> <ul style="list-style-type: none"> ✓ Life and Disability Income Insurance Application ✓ Authorization for Release of Health-Related Information to RiverSource Life Insurance Company ✓ Bank Authorization (BA)/Systematic Payout (SPO) form ✓ Notice and Consent Form for AIDS Virus (HIV) Testing ✓ <i>AdvanceSource</i>® Accelerated Benefit Rider Application ✓ Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance ✓ Notice to Applicant Regarding Replacement of Accident and Sickness Insurance ✓ Investment Option Allocation ✓ Portfolio Navigator Program Enrollment/Change Request for Variable Life Insurance ✓ Annuity Systematic Payout Transaction Request ✓ Workplace Investing (WPI) Payroll Deduction Form For Employees of Ameriprise Financial ✓ Cash Distributions - Brokerage/Managed Accounts ✓ Electronic Funds Transfer - Outgoing ACH/Check Brokerage/Manager Accounts Systematic Payout Application (Beta) ✓ Employer/Plan Sponsor Group Billing Arrangement Setup and Changes Form ✓ Mutual Fund and Certificate Redemption, Exchange and/or Transfer of Investment
4	Copyright statement.	Bracketed in case copyright year changes with future application updates of variable items.
5	Administrative information	The version letter/print date will be changed if any future changes are made to items bracketed as variable. The range will be A-Z except never "B, I, O, Q or S". The date range will also use 1-12 for the months and the last two numbers of a year, from 2011 and beyond.

Forms List - Previously Approved Base Policies - State of Arkansas

Individual Life-DI Application 134886 and Electronic Signature form 131244 will be issued with all of the previously approved policy and supplemental application forms listed below.

Description	Form Number	Status	Approval Date	State/SERFF File #
Variable Life Insurance Policy Forms				
Variable Universal Life (VUL)	30061-AR	approved	06/16/1998	
Succession Select Survivorship Life	30090C	approved	02/20/2001	
Fixed Life Insurance Policy Forms				
Foundations Protector universal life (FP)	133078-AR	approved	12/15/2005	
Foundations universal life (FUL)	ICC11 132298	Approved	08/18/2011	IC11-00138
Flexible Premium Adjustable Life Insurance Policy with Indexed-Linked Interest Option(s) (IUL)	ICC11 132300	Approved	08/18/2011	IC11-00138
Succession Protector Survivorship Life	134581-AR	approved	09/27/2006	33766
Term Insurance - 10 Year	30480A-AR	approved	09/02/2003	
Term Insurance - 15 & 20 Year	30470A-AR	approved	09/02/2003	
Income Protection Life	132289	Approved	05/12/2010	09/21/2023
Disability Income Insurance Policy Forms				
Disability Income Insurance IPP 2	30200G	Approved	06/25/2007	36199
Disability Income Insurance IPP 5	30203G	Approved	06/26/2007	36204
Disability Income Insurance IP Plus	30205G	Approved	06/26/2007	36205
Disability Income Insurance IP Tr	30207G	Approved	06/26/2007	36203
Disability Income Insurance IP Mod	30208G	Approved	06/26/2007	36201
Disability Income Insurance BOE	30209C	Approved	07/11/1994	
Supplemental Application Forms				
Insurance Application Supplement	133081	Approved	02/17/2010	44823
Advance Source® ABR Application	132263	Approved	02/17/2010	44823