Filing at a Glance

Company: Pacific Life Insurance Company

Product Name: UL/LTC Combo	SERFF Tr Num: PALD-127383193	State: Arkansas
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed-Approved-Closed	State Tr Num: 49651
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: PACIFIC PREMIERCARE	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird, Stephanie Fowler
	Author: Greg Guzman	Disposition Date: 10/31/2011
	Date Submitted: 08/26/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Overall Rate Impact:
Filing Status Changed: 10/31/2011	
State Status Changed: 10/31/2011	Deemer Date:
Created By: Greg Guzman	Submitted By: Greg Guzman

Corresponding Filing Tracking Number:

Filing Description:

Re: Individual Life Insurance/Long-Term Care (LTC) Combination Filing

Life Form

P11PPC Flexible Premium Adjustable Life Insurance

LTC Riders

R11ABR Accelerated Benefit Rider (“ABR”) for Long-Term Care

R11EBR Extended Benefit Rider (“EBR”) for Long-Term Care

E11LRD Limited Refund on Death Endorsement

Life/LTC Rider
R11AVT Aviation Exclusion Rider

LTC Form
N11OOC Outline of Coverage

Life/LTC Applications
A11PPC Application for Pacific PremiereCare for Individual Life Insurance with Long-Term Care (LTC) Benefits
A11SOH Statement of Good Health and Insurability
A11TIA Pacific PremierCare Temporary Insurance Agreement (TIA)

We are submitting the above referenced individual (non-group) life insurance and LTC forms in final print for your approval. The life policy, the LTC riders, and the applications are new forms, which do not replace any previously approved forms. Policy form P11PPC is a flexible premium universal life policy combined with riders R11ABR, an accelerated death benefit rider with an LTC trigger and R11EBR, which provides LTC benefits.

Provided below and on the following page are descriptions of the submitted forms:

P11PPC- Flexible Premium Adjustable Life Insurance

Policy form P11PPC is a flexible premium universal life policy which is intended to be funded with a single premium, however, additional premiums will be allowed. The single premium required at issue is sufficient to keep the policy in force through age 95. If any additional premiums are paid after issue of the policy, these will be added to the Accumulated Value, unless doing so would result in the policy becoming a Modified Endowment Contract, in which case the premium would be returned. Additionally, there is a return of premium feature. An accelerated living benefit (Terminal Illness Benefit) feature is built into the policy.

R11ABR & R11EBR-Accelerated Benefit Rider (“ABR”) for Long-Term Care & Extended Benefit Rider (“EBR”) for Long-Term Care

Rider form R11ABR is a LTC triggered benefit which accelerates payment of the universal life policy’s face amount for payment of qualified LTC expenses. Rider R11EBR is an optional rider, which extends the benefits provided under the ABR for an additional period, one through six years after the exhaustion of the ABR benefits. Both riders include an inflation benefit option which adjusts the maximum monthly benefits annually. Furthermore, both riders provide a return of premium feature.

E11LRD-Limited Refund on Death Endorsement

This endorsement provides the Limited Refund on Death benefit, which is a refund of premiums paid for ABR and EBR. This endorsement is issued when the initial Death Proceeds are less than the total premium paid.

R11AVT-Aviation Exclusion Rider

This is a rider which excludes aviation risks and the underwriters determine if this exclusionary rider is issued.

N11OCC-Outline of Coverage

This form will be provided to each individual who considers applying for the Life/LTC combination policy. This outline describes the LTC benefits.

A11PPC-Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits

This is the main application used to apply for the universal life policy and the LTC riders. This application will be used as a paper application or in an electronic/telephonic process.

A11SOH-Statement of Good Health and Insurability

This is a form the insured signs, stating there have been no health changes since the date of the telephone interview.

A11TIA-Pacific PremiereCare Temporary Insurance Agreement (TIA)

This form provides a limited amount of life insurance coverage, for a limited period of time.

Supporting Documentation

We are submitting the following forms on an informational basis: Pacific PremierCare Ticket and the life replacement notices.

These forms are submitted as part of this filing for information only:

N11TYK Things You Should Know Before You Buy Long-Term Care Insurance
M11SPW Long-Term Care Insurance Personal Worksheet
M11SLT Long-Term Care Insurance Suitability

M11RPL Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance
A11ARI Authorization to Release Information
A11AUT Authorization to Obtain Information
A11DIS Disclosure Notice – How We Use Your Information
N11PHI Privacy Notice for Personal Health Information

Electronic Signature of Forms

In accordance with the electronic transactions and signature laws, we will accept electronic signatures via personal or telephone interview, on the documents submitted in this filing. The electronic document will look identical to the hard copy document when it is printed and attached to the policy, as part of the entire contract provision. As part of the eSignature process, each signer is given a link for access. That link is unique to each user and unique to that signing event, allowing the signer's electronic signature to be affixed to the document only once. The link is encrypted for a one time use. This access procedure prevents any future authorized or unauthorized reproduction of the signature. Note, a traditional wet signature will continue to be accepted on the documents.

Request for Confidentiality

Pacific Life would like to make a trade secret request for the product rates on our LTC riders.

The confidentiality of Pacific Life's LTC rider rates is also critical in maintaining a timing advantage over competing life insurance companies. While product rates might be partially available after the launch of the product and riders, other companies could gain a competitive head start if they were able to obtain our LTC rider rates before the introduction of the product.

Therefore, Pacific Life would like to have our rider rates provided in this filing considered trade secret. The rates are included in Appendix A of the Actuarial Memorandum.

Thank you for your consideration of this request.

Additional Information Pertaining to this Submission

• Actuarial memoranda and certifications are included in this filing.
• Two questionnaires, the Aviation Questionnaire, A03AVI and the Avocation Questionnaire, A03AVO approved on 8/18/03, will be used with the application A11PPC.
• Rate schedules and sample mortality and morbidity assumptions are included in this filling.

• A Readability Certification is included in this filing.
• Issue Ages are 30-75. Minimum issue amount is $50,000.
• This form will be marketed through our licensed agents. The target release is 1/1/12, or upon approval.
• This policy is issued on a sex-distinct basis and will not be issued in any employer-employee situation subject to the Norris decision and/or title VII of the Civil Rights Act of 1964 with unisex rates.
• These forms will not be illustrated, therefore a Statement of Policy Cost and Benefit Information (Illustrative Quote) that reflects guaranteed values will be provided to each proposed insured.

To the best of my knowledge and belief this filing complies with your state's laws and regulations. If you would like to discuss any aspect of this filing, please feel free to contact me at (800) 800-6416, extension 8483 or by e-mail, LifeProductCompliance@pacificlife.com.

Sincerely,

Greg Guzman
Senior Compliance Analyst

Company and Contact

Filing Contact Information

Greg Guzman, Senior Compliance Analyst	greg.guzman@pacificlife.com
45 Enterprise	800-800-7681 [Phone] 8483 [Ext]
Aliso Viejo, CA 92656	

Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	$450.00
Retaliatory?	Yes
Fee Explanation:	$50 multiplied by the 9 forms included in the Form Schedule.

SERFF Tracking Number:	*PALD-127383193*	*State:*	*Arkansas*
Filing Company:	*Pacific Life Insurance Company*	*State Tracking Number:*	*49651*
Company Tracking Number:	*PACIFIC PREMIERCARE*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*UL/LTC Combo*		
Project Name/Number:	*/*		

$50 x 9 = $450

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pacific Life Insurance Company	$450.00	08/26/2011	51009827

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/31/2011	10/31/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	09/26/2011	09/26/2011	Greg Guzman	10/19/2011	10/26/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Certificatons	Greg Guzman	10/27/2011	10/27/2011

Disposition

Disposition Date: 10/31/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PALD-127383193*	*State:*	*Arkansas*
Filing Company:	*Pacific Life Insurance Company*	*State Tracking Number:*	*49651*
Company Tracking Number:	*PACIFIC PREMIERCARE*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*UL/LTC Combo*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document *(revised)*	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		Yes
Supporting Document *(revised)*	Health - Actuarial Justification		No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document *(revised)*	Outline of Coverage		Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document *(revised)*	Supporting Documentation		Yes
Supporting Document	Supporting Documentation	Replaced	Yes
Supporting Document *(revised)*	Statement of Variability		Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	Comparison Documents		Yes
Supporting Document	Complaint & Guaranty Association Notices		Yes
Supporting Document *(revised)*	Certificatons		Yes
Supporting Document	Certificatons	Replaced	Yes
Form *(revised)*	Flexible Premium Adjustable Life Insurance		Yes
Form	Flexible Premium Adjustable Life Insurance	Replaced	Yes
Form *(revised)*	Accelerated Benefit Rider (“ABR”) for Long-Term Care		Yes
Form	Accelerated Benefit Rider (“ABR”) for Long-Term Care	Replaced	Yes
Form *(revised)*	Extended Benefit Rider (“EBR”) for Long-Term Care		Yes
Form	Extended Benefit Rider (“EBR”) for Long-Term Care	Replaced	Yes
Form	Limited Refund on Death Endorsement		Yes
Form *(revised)*	Aviation Exclusion Rider		Yes
Form	Aviation Exclusion Rider	Replaced	Yes
Form *(revised)*	Outline of Coverage		Yes
Form	Outline of Coverage	Replaced	Yes
Form *(revised)*	Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits		Yes

Form	Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits	Replaced	Yes
Form *(revised)*	Statement of Good Health and Insurability		Yes
Form	Statement of Good Health and Insurability	Replaced	Yes
Form *(revised)*	Pacific PremierCare Temporary Insurance Agreement (TIA)		Yes
Form	Pacific PremierCare Temporary Insurance Agreement (TIA)	Replaced	Yes
Form	Foreign Residence and Travel Questionnaire - Future		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/26/2011
Submitted Date	09/26/2011
Respond By Date	10/26/2011

Dear Greg Guzman,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised fiings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Regulation 49 requires that a LIfe and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Filings of "universal life" type contracts are subject to Regulation 34. Please assure us that you are in compliance with Regulation 34. If cost of insurance may be changed by the company subject to a maximum and/or accumulation rates may be changed by the company subject to a minimum, then the contract must comply with Bulletin 11-83.

Please refer to policy General Provisions under the Suicide Exclusion provision. After the incontestable period expiration you may not restart upon reinstatement. Review Ark. Code Ann. 23-81-115(a)(2)(E).

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/19/2011
Submitted Date	10/26/2011

Dear Stephanie Fowler,

Comments:

Response 1

Comments: Please see attached notice "ST81" which complies with Ark. Code Ann. 23-79-138.

We have uploaded "Arkansas Certification - P11PPC to comply with Regulation 19s10B.

Notice "AR1" was uploaded to meet Regulation 49.

"Arkansas Reg 34 Certificatie of Compliance" was uploaded to fulfill Reg 34.

Our suicide exclusion provision was modified on form P11PPC to comply with Ark. Code Ann. 23-81-115(a)(2)(E).

Please note that we have included a foreign residence and travel questionnaire to the Form Schedule. The questionnaire may be used as part of the application process.

As we discussed last week, I have submitted comparison documents within the Supporting Documentation section to illustrate changes made to our forms since our initial filing.

Related Objection 1

Comment:
Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

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Filings of "universal life" type contracts are subject to Regulation 34. Please assure us that you are in compliance

with Regulation 34. If cost of insurance may be changed by the company subject to a maximum and/or accumulation rates may be changed by the company subject to a minimum, then the contract must comply with Bulletin 11-83.

Please refer to policy General Provisions under the Suicide Exclusion provision. After the incontestable period expiration you may not restart upon reinstatement. Review Ark. Code Ann. 23-81-115(a)(2)(E).

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Flesch Certification
Comment:
Satisfied -Name: Health - Actuarial Justification
Comment:
Satisfied -Name: Outline of Coverage
Comment: This is the same outline of coverage that is included in the Form Schedule.
Satisfied -Name: Supporting Documentation
Comment: The following documents are submitted as informational:

Authorization to Obtain Information
Authorization to Release Information
Disclosure Notice - How We Use Your Information
Privacy Notice for Personal Health Information
Things You Should Know Before You Buy LTC
Long Term Care Insurance Suitability
Long Term Care Personal Worksheet
Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance
Pacific PremierCare Ticket
Life Replacement Notice
Satisfied -Name: Statement of Variability
Comment:
Satisfied -Name: Comparison Documents
Comment:
Satisfied -Name: Complaint & Guaranty Association Notices
Comment:
Satisfied -Name: Certificatons
Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Flexible Premium Adjustable Life Insurance	P11PPC		Policy/Contract/Fraternal Certificate	Initial		50.100	P11PPC AR.pdf
Previous Version							
Flexible Premium Adjustable Life Insurance	*P11PPC*		*Policy/Contract/Fraternal Certificate*	*Initial*		*50.100*	P11PPC.pdf
Accelerated Benefit Rider (“ABR”) for Long-Term Care	R11ABR		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		50.000	R11ABR.pdf
Previous Version							
Accelerated Benefit Rider (“ABR”) for Long-Term Care	*R11ABR*		*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*		*50.000*	R11ABR.pdf
Extended Benefit Rider (“EBR”) for Long-Term Care	R11EBR		Certificate	Initial		50.000	R11EBR.pdf
Previous Version							
Extended Benefit Rider (“EBR”) for Long-Term Care	*R11EBR*		*Certificate*	*Initial*		*50.000*	R11EBR.pdf
Aviation Exclusion Rider	R11AVT		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		50.100	R11AVT.pdf
Previous Version							
Aviation Exclusion Rider	*R11AVT*		*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*		*50.100*	R11AVT.pdf
Outline of Coverage	N11OOC		Outline of Coverage	Initial		0.000	N11OOC.pdf
Previous Version							

Outline of Coverage	*N11OOC*	*Outline of Coverage*	*Initial*	*0.000*	Outline of Coverage.pdf
Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits	A11PPC	Application/Enrollment Form	Initial	50.200	A11PPC.pdf
Previous Version					
Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits	*A11PPC*	*Application/Enrollment Form*	*Initial*	*50.200*	A11PPC.pdf
Statement of Good Health and Insurability	A11SOH	Application/Enrollment Form	Initial	50.600	A11SOHS.pdf
Previous Version					
Statement of Good Health and Insurability	*A11SOH*	*Application/Enrollment Form*	*Initial*	*50.600*	A11SOH.pdf
Pacific PremierCare Temporary Insurance Agreement (TIA)	A11TIA	Application/Enrollment Form	Initial	50.100	A11TIAS.pdf
Previous Version					
Pacific PremierCare Temporary Insurance Agreement (TIA)	*A11TIA*	*Application/Enrollment Form*	*Initial*	*50.100*	A11TIA.pdf
Foreign Residence and Travel Questionnaire - Future	A11TFU	Application/Enrollment Form	Initial	52.900	A11TFU.pdf

No Rate/Rule Schedule items changed.

Sincerely,

Greg Guzman

Amendment Letter

Submitted Date: 10/27/2011

Comments:

Reg 34 certification was inadvertantly left out of our response yesterday. I have added the signed and completed form to Supporting Documentation.

Thank you,

Greg Guzman

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Certificatons

Comment:

Arkansas Certification - P11PPC.pdf

Arkansas Reg 34 Certificate of Compliance.pdf

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	P11PPC	Policy/Contract/Fraternal Certificate	Flexible Premium Adjustable Life Insurance	Initial		50.100	P11PPCAR.pdf
	R11ABR	Certificate Amendment, Insert Page, Endorsement or Rider	Accelerated Benefit Rider (“ABR”) for Long-Term Care	Initial		50.000	R11ABR.pdf
	R11EBR	Certificate	Extended Benefit Rider (“EBR”) for Long-Term Care	Initial		50.000	R11EBR.pdf
	E11LRD	Certificate	Limited Refund on Death Endorsement	Initial		70.600	E11LRD.pdf
	R11AVT	Certificate Amendment, Insert Page, Endorsement or Rider	Aviation Exclusion Rider	Initial		50.100	R11AVT.pdf
	N11OOC	Outline of Coverage	Outline of Coverage	Initial		0.000	N11OOC.pdf
	A11PPC	Application/Enrollment Form	Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits	Initial		50.200	A11PPC.pdf
	A11SOH	Application/Enrollment	Statement of Good Health and	Initial		50.600	A11SOHS.pdf

A11TIA	Form Application/ Enrollment Form	Insurability Pacific PremierCare Temporary Insurance Agreement (TIA)	Initial	50.100	A11TIAS.pdf
A11TFU	Application/ Enrollment Form	Foreign Residence and Travel Questionnaire - Future	Initial	52.900	A11TFU.pdf

Pacific Life Insurance Company • [45 Enterprise • Aliso Viejo, CA 92656]
[www.PacificLife.com (800) 347-7787]

READ YOUR POLICY CAREFULLY. This is a legal contract between you, the Owner, and us, Pacific Life Insurance Company, a stock insurance company. We agree to pay the benefits of this policy according to its provisions. The consideration for this policy is the Application for it, a copy of which is attached, and payment of the initial premium.

The method for determining the Death Benefit is described in the Death Benefit section of this policy. The amount of the Death Benefit may decrease as a result of withdrawals or paid policy or rider benefits.

Premiums are flexible, subject to minimums required to keep the policy In Force. It is possible that, due to loans against the policy Accumulated Value, the policy may not continue In Force; that is, it may lapse before any Death Benefit is payable on the death of the Insured.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Benefit Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**
- **Terminal Illness Benefit (Accelerated Death Benefit)**

Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Number:	[LTC6999990]
Policy Date:	[November 1, 2011]

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Free Look Right – The Owner has 30 days from the day the policy and any riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the policy and riders. The policy and riders can be returned to us at our Administrative Office or to the Producer through whom they were bought. We will refund, directly to the payer, the full amount of any premium paid within 30 days of such a return and the policy and any riders will be void from the start.

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POLICY SPECIFICATIONS

Summary of Coverages Effective on the Policy Date

P11PPC	Flexible Premium Adjustable Life Insurance (Life Coverage)
R11ABR	Accelerated Benefit Rider (“ABR”) for Long-Term Care
[R11EBR	Extended Benefit Rider (“EBR”) for Long-Term Care]

Life Policy:	Flexible Premium Adjustable Life Insurance
Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Date:	[November 1, 2011]
Sex And Age:	[Female 35]
Risk Class:	[Nonsmoker] [with Couples Discount]
Death Benefit Qualification Test:	Cash Value Accumulation Test
Net Amount at Risk Factor:	[1.0029919]
[This Policy Is a Modified Endowment Contract]	
[7 Pay Premium:	$1,416.00]
Guaranteed Annual Interest Rate:	[3.65%]
Monthly Deduction End Date:	Policy Anniversary When the Insured Attains Age 95
Surrender Charge	
Initial Amount:	[$757.00]
Level Period:	[5] Years
Reduction Factor:	[$151.40]
Surrender Charge Period:	[10] Years
Maximum Monthly Coverage Charge	
Years 1 -10:	[$16.88]
Year 11 +:	[$0.00]

Summary of Values Effective on the Policy Date

Death Proceeds (Before Minimum Death Benefit)	**Benefit Amount**
Face Amount (Life Coverage):	[$50,000.00]
Death Proceeds:	[$50,000.00]

Coverage Type	**Premium Amount**
Life Coverage:	[$12,081.50]
Accelerated Benefit Rider (ABR):	[$3,143.50]
[Extended Benefit Rider (EBR):]	[$3,520.00]
Total Premium:	[$18,748.00]
Return of Premium Benefit:	[$18,748.00]

Long-Term Care Benefit Limits	**Elected Benefit Duration**	**Benefit Amount**
Maximum ABR Benefit Limit:	2 Years	[$50,000.00]
[Maximum EBR Benefit Limit:]	[4 Years]	[$100,000.00]
[Minimum Inflation Benefit Option:]		[11,250.00]
Total Long-Term Care Benefit:	[6 Years]	[$161,250.00]
Monthly Maximum ABR [and EBR] Benefit Amount:		[$2,083.33]
Inflation Benefit Option for ABR [and EBR]:		[Rejected] [3% Simple]

Long-Term Care Benefits	**Elimination Period**
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[90] Days
Care Coordination Benefit:	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[90] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[90] Days

Non-Continual Alternative Care Benefit Lifetime Maximum – Lesser of $5,000 or Monthly Maximum ABR Benefit Amount at time of policy issue while covered under ABR [and EBR].

Caregiver Training Benefit Lifetime Maximum – $1,000 for the Caregiver Training Benefit while covered under ABR [and EBR].

For questions about your policy or to discuss policy and rider benefits, you may contact us at our Administrative Office at (800) 347-7787or at www.PacificLife.com.

TABLE OF COST OF INSURANCE RATES

FOR LIFE COVERAGE

INSURED: [JANE DOE]

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

POLICY YEAR	MONTHLY RATE	POLICY YEAR	MONTHLY RATE
[1	0.07670	45	3.43850
2	0.08250	46	3.82530
3	0.08750	47	4.30290
4	0.09170	48	4.81110
5	0.09670	49	5.34790
6	0.10260	50	5.95010
7	0.10920	51	6.56440
8	0.11670	52	7.29570
9	0.12590	53	8.20720
10	0.13680	54	9.17860
11	0.14930	55	10.15600
12	0.16430	56	10.88250
13	0.18180	57	11.58260
14	0.20110	58	12.75540
15	0.22280	59	14.36970
16	0.24700	60	16.42160
17	0.27460	61+	0.00000]
18	0.30550		
19	0.33810		
20	0.37240		
21	0.41180		
22	0.45450		
23	0.49970		
24	0.54660		
25	0.59440		
26	0.64480		
27	0.70020		
28	0.75900		
29	0.82120		
30	0.88930		
31	0.96510		
32	1.04770		
33	1.13960		
34	1.24180		
35	1.35340		
36	1.47950		
37	1.62360		
38	1.78150		
39	1.95420		
40	2.14600		
41	2.35700		
42	2.58910		
43	2.84660		
44	3.12830		

DEFINITIONS

In this section, we define certain terms used throughout this policy. Other terms may be defined in other parts of the policy. Defined terms are usually capitalized to provide emphasis.

Accumulated Value – is the sum of Net Premiums and credited interest less withdrawals, monthly deductions, and any reductions due to the Terminal Illness Benefit Payment or benefit payments under a rider. See the Accumulated Value and Policy Loan sections for details.

Administrative Office – is the office that administers your policy. The mailing address of the Administrative Office at the time you applied for this policy is shown in the heading of the Application. If the address changes, we will send you written notice of the new address.

Age – means the age as of the Insured's birthday prior to the Policy Date, increased by the number of complete policy years elapsed.

Application – consists of the application for this policy, including any Statement of Good Health and Insurability, amendments, endorsements, and any application for reinstatement.

Class – is used in determining policy charges and interest credited, and depends on a number of factors, including (but not limited to) the Death Benefit, Face Amount, Policy Date, policy duration, the Insured's Age and Risk Class and the presence of optional riders and benefits.

Code – is the U.S. Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

Evidence of Insurability – is information, including medical information, that is used to determine insurability and the Insured's Risk Class, subject to our approval.

Face Amount – is the Face Amount of Life Coverage as shown in the Policy Specifications.

Insured – is the person insured under this policy, as shown in the Policy Specifications.

In Force – means a policy is in effect and provides a Death Benefit or Residual Death Benefit on the Insured.

Life Coverage – is insurance coverage on the Insured provided by this policy as shown in the Policy Specifications, rather than coverage provided by rider.

Monthly Deduction End Date – is shown in the Policy Specifications and is the date when Monthly Deductions end.

Monthly Payment Date – is the same day in each month as the Policy Date and is the date on which certain policy charges are deducted from the Accumulated Value. The first Monthly Payment Date is the Policy Date.

Net Accumulated Value – is the Accumulated Value less any Policy Debt.

Net Amount at Risk – is the difference between the Death Benefit and the Accumulated Value.

Net Premium – is the premium we receive for Life Coverage.

Owner, you, or your – refers to the Owner of this policy.

Policy Date – is shown in the Policy Specifications and means the date the policy and associated riders become effective. Policy and rider months, quarters, years and anniversaries are measured from this date.

Policy Debt – is the sum of the Loan Account and accrued Loan Interest charged.

Policy Specifications – is a section of the policy that shows information specific to your policy.

Risk Class – is used in determining policy charges and is determined by us during the underwriting process. Risk Class depends on the Insured's gender, health, tobacco use, and other factors. The Risk Class of the Insured is shown in the Policy Specifications. Risk Class may also be referred to as Risk Classification.

We, our, ours, and us – refers to Pacific Life Insurance Company.

Written Request – is your signed request in writing, or on a form we provide, and received by us at our Administrative Office, containing information we need to act on the request.

DEATH BENEFIT

When the Policy is In Force – This policy is In Force as of the Policy Date, subject to your acceptance of the delivered policy and payment of the initial premium. The policy remains In Force until the earliest of the following:

- Surrender, as described in the Surrender and Withdrawal of Values section;
- Lapse, as described in the Policy Lapse and Reinstatement section; or
- The death of the Insured.

Coverage under this policy will be reduced by any decreases in Face Amount, as described in later sections of this policy or riders attached to this policy.

Death Benefit – This policy provides a Death Benefit on the death of the Insured while this policy is In Force. This section describes how the Death Benefit is calculated. The Death Benefit is the larger of:

- The Face Amount reflecting any reductions as a result of withdrawals, any Terminal Illness Benefit Payment, or any rider benefits paid; or
- The Minimum Death Benefit according to the Cash Value Accumulation Test.

The Death Benefit as calculated above is subject to any increase required by the minimum death benefit provisions set out in General Provisions to satisfy certain federal tax qualification requirements.

Death Benefit Qualification Test – In order for your policy to qualify as a life insurance contract under the Code, it must at all relevant times satisfy the Cash Value Accumulation Test. The policy provides a Minimum Death Benefit amount, as needed, for the policy to qualify under the Cash Value Accumulation Test.

Minimum Death Benefit – The Minimum Death Benefit at any time will be the minimum amount required for this policy to qualify as a life insurance contract under the Code, but not less than 101% of the greater of the Accumulated Value or the Life Return of Premium Benefit.

Death Proceeds – The Death Proceeds ("Proceeds") amount is the actual amount payable to the beneficiary if the Insured dies while this policy is In Force. The Proceeds amount is equal to the greater of the Death Benefit or the Residual Death Benefit, as of the date of death:

- Less any Policy Debt; and
- Less any Monthly Deductions that may be due and unpaid if death occurs during a Grace Period.

Proceeds paid are subject to the conditions and adjustments defined in other policy provisions, such as General Provisions, withdrawals, Policy Loans, and Timing of Payments. We will pay interest on the Proceeds from the date of death at a rate not less than the rate payable for funds left on deposit (see the Income Benefits section). If payment of Proceeds is delayed more than 31 calendar days after we

receive the following requirements needed to pay the claim, we will pay additional interest at a rate of 10% annually beginning with the 31st calendar day referenced above. Proceeds are paid as a lump sum unless you choose to have the Proceeds paid under an income benefit plan available on the date of election, subject to our requirements.

We will pay the Proceeds to the beneficiary after we receive, at our Administrative Office:

- Due proof of the Insured's death, consisting of a certified copy of the death certificate for the Insured or other lawful evidence providing equivalent information;
- Proof of the claimant's legal interest in the Proceeds; and
- Sufficient evidence that any legal impediments to payment of Proceeds that depend on parties other than us have been resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; (c) submission of information required to satisfy state and federal reporting requirements; and (d) conflicting claims.

Residual Death Benefit – This policy provides a Residual Death Benefit if greater than the Death Benefit, in an amount equal to the lesser of 5% of the initial Face Amount, as shown on the Policy Specifications, or $5,000.00. Any withdrawals and any Terminal Illness Benefit Payment will reduce the Residual Death Benefit in the same proportion that they reduce the Face Amount.

Face Amount Changes – A requested increase or decrease in Face Amount is not allowed.

Face Amount Decreases – A decrease in Face Amount will occur as a result of:

- Withdrawals of policy Accumulated Value; or
- Rider benefits or Terminal Illness Benefit exercised while the policy is In Force.

The effective date of the decreased Face Amount will be the date we have processed the withdrawal, rider benefit, or Terminal Illness Benefit. Upon processing any decrease, we will send you written notification reflecting the decrease.

Change in Benefits – Under the Cash Value Accumulation Test, any change in policy or rider benefits or certain other factors may require an adjustment to the policy's tax qualification limits.

PREMIUMS

Premiums – The initial premium is payable either at our Administrative Office or to our authorized representative before we can place your policy In Force. At your request, we will give you a premium receipt signed by one of our officers. Additional premiums are optional and are payable at any time at our Administrative Office. We will consider any premium paid after the initial premium, whether delivered to an independent producer or otherwise, to be "received" when it is actually delivered to our Administrative Office. Except for the initial premium, we bear no responsibility for any premium unless we have received the premium. We reserve the right to reject premium payments less than $50 unless such premium is required to keep the policy In Force. Premiums may be paid at any time before the Monthly Deduction End Date, subject to the premium limits below. Any payment we receive from you while you have a loan will be first considered a loan repayment, unless you tell us by Written Request it is a premium payment.

Premium Processing – When a premium is received by us, the Net Premium will be credited to the Accumulated Value.

Premium Limitation – We reserve the right to require Evidence of Insurability satisfactory to us for any premium payment that would result in an increase in the Net Amount at Risk and, if such Evidence of Insurability is not satisfactory, to limit or refuse the premium payment, unless it is necessary to keep the policy In Force.

Modified Endowment Contract Premium Limit – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract under Section 7702A of the Code as of the Policy Date. Otherwise, in order that this policy not be classified as a Modified Endowment Contract under Section 7702A of the Code, the sum of premiums paid less a portion of any withdrawals may not exceed the 7-Pay limit as defined in the Code. The 7-Pay limit is the cumulative sum of the 7-Pay Premiums during the applicable 7-Pay testing period. In the event that a premium payment would cause the 7-Pay limit to be exceeded, we will refund the excess payment to you, unless you have provided a Written Request in which you accept your policy being classified as a Modified Endowment Contract and indicate that we may accept such payments and apply them to the policy, in accordance with the Modified Endowment Contract Tax Status subsection of this policy.

The 7-Pay Premium may change whenever there is a change in the Face Amount of insurance or in other policy benefits or factors. The 7-Pay Premiums are determined according to the rules applicable to this policy set forth in the Code. The 7-Pay Premium will be adjusted to conform to any changes in the Code. To the extent that a premium payment would cause such limits to be exceeded, we will refund the excess payment to you, in accordance with the Modified Endowment Contract Tax Status section of this policy. Further, as indicated in that section, we will increase the Death Benefit to the extent we deem necessary to continue to classify this policy as a non-Modified Endowment Contract under the Code.

TERMINAL ILLNESS BENEFIT

Terminal Illness Benefit – If the Insured has been diagnosed with a terminal illness, you have the option to receive a portion of the Face Amount while the Insured is still living. This is called a Terminal Illness Benefit. A "terminal illness" means an illness causing the Insured to have a life expectancy of 12 months or less.

Eligible Coverage – is the portion of the Face Amount that will qualify for determining the Terminal Illness Benefit at the time the benefit is exercised. Eligible Coverage is the policy Face Amount less any reductions as a result of withdrawals or paid rider benefits on the policy.

Requested Portion – is the amount of the Face Amount you request in a Written Request on a form provided by us. The Requested Portion cannot exceed the lesser of 75% of the Eligible Coverage or $500,000.

Requested Percentage – is the Requested Portion divided by the Eligible Coverage.

Terminal Illness Benefit Payment – is the actual dollar amount of benefit you will receive as a Terminal Illness Benefit. The Terminal Illness Benefit Payment will be determined as of the date we approve your Written Request for a Terminal Illness Benefit. Your Terminal Illness Benefit Payment will equal your Requested Portion less the following adjustments:

a) A reduction rate will be applied to the Requested Portion, and reflects the early payment of the Requested Portion of your policy. The reduction rate will be based on the12 month life expectancy of the Insured at an annual interest rate declared by us. The reduction rate shall be no greater than the greater of the following rates in effect on the date of your written request for a Terminal Illness Benefit:
   i) the yield on 90-day treasury bills; or
   ii) the maximum statutory adjustable policy loan interest rate.

b) If there is a Policy Loan on your policy as of the date we approve your Written Request, we will reduce the Requested Portion in order to repay a portion of the Policy Loan equal to the Requested Percentage times the outstanding loan.

c) A processing charge deducted from the Terminal Illness Benefit, not to exceed $150.

We will refund the amounts discussed in a) and c) above should the death of the Insured occur within 30 days of the Terminal Illness Benefit Payment.

The Terminal Illness Benefit Payment will be paid as a lump sum. The minimum Terminal Illness Benefit Payment amount is $500. We place no restrictions on how you use any Terminal Illness Benefit that may be paid under this provision.

This Terminal Illness Benefit is not meant to cause involuntary access to proceeds payable to the beneficiary on the death of the Insured. Therefore, this benefit is not available if either you or the Insured:

a) is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or

b) is required by a government agency to use this benefit in order to apply for, obtain or keep a government benefit or entitlement.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner or the Owner's estate while the Insured is still living, unless otherwise assigned or designated by the Owner, subject to any required acknowledgment of concurrence for payout. We will be discharged to the extent of any such payment made in good faith.

Effect of Terminal Illness Benefit Payment on Policy and Riders – After a Terminal Illness Benefit Payment is made, the policy and riders will remain In Force subject to the following adjustments. The Face Amount, Coverage Charge, and any Accumulated Value will be reduced by the Requested Percentage. The Return of Premium Benefit will be reduced by the Requested Portion corresponding to the Terminal Illness Benefit Payment amount paid. Any outstanding Policy Loan balance will be reduced as specified in the Terminal Illness Benefit Payment Section. Cost of Insurance Charges will be adjusted to reflect the reduction in the Death Benefit. A statement demonstrating how the Terminal Illness Benefit impacts your policy values will be sent with the Terminal Illness Benefit Payment.

Eligibility – The following conditions must be met before any Terminal Illness Benefit Payment is made:

- The policy must be In Force on the date the Terminal Illness Benefit Payment is approved;
- We must receive written proof that the life expectancy of the Insured is 12 months or less from the date of the Written Request. Proof will include the certification by a licensed physician. Such person may not be you or a member of your family. Such proof should include clinical, radiological or laboratory evidence of the condition. We reserve the right to obtain a second medical opinion from a physician of our choice at our expense. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion, at our expense, that is provided by a physician that is acceptable to you and to us.
- The Owner or legal guardian must make the Written Request.

The Terminal Illness Benefit Payment will be paid immediately upon receipt of the due written proof of eligibility.

- **Terminal Illness Benefit Payment Notice –** Prior to or concurrent with the election to effect the Terminal Illness Benefit Payment, we will send the Owner, a statement demonstrating the effect of the Terminal Illness Benefit Payment on the Accumulated Value, Death Benefit, Premium, Cost of Insurance Charges, and Policy Loans (including loans to pay premiums).

Expiration Date – Your right to exercise the Terminal Illness Benefit will end when the policy is no longer In Force, when the Accumulated Value is zero, or when a Terminal Illness Benefit is paid.

Disclosure – The following should be taken into consideration before you exercise your option to receive the Terminal Illness Benefit:

- Policy Death Benefits, Coverage Charge, Accumulated Value, and Cash Surrender Value will be reduced if a Terminal Illness Benefit is paid;
- This Terminal Illness Benefit is NOT health, nursing home or long-term care insurance, and it is not intended or designed to eliminate the need for such coverage;
- Receipt of the Terminal Illness Benefit Payment may affect Medicaid, Medicare, and/or Supplemental Security Income (SSI) eligibility. Exercising the option to accelerate and receive benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility.

ACCUMULATED VALUE

Accumulated Value – The Accumulated Value equals the sum of:

- Fixed Accumulated Value; and
- Loan Account Value, as described in the Policy Loans section.

Fixed Accumulated Value – On the Policy Date, the Fixed Accumulated Value equals the Net Premium received less the first Monthly Deduction. On each other day, the Fixed Accumulated Value equals:

- The Fixed Accumulated Value as of the prior day;
- Plus interest earned on such amount since the prior day;
- Plus the amount of any Net Premiums received since the prior day;
- Less the amount of any withdrawal since the prior day;
- Less the amount of any Policy Loan, including any Policy Loan to pay Policy Loan interest, taken since the prior day;
- Less reduction for benefits paid since the prior day as described in the riders attached to this policy;
- Less reduction for the Requested Portion for any Terminal Illness Benefit Payment since the prior day as described in the Terminal Illness Benefit section;
- Plus the amount of any loan repayment made since the prior day; and
- Less, on a Monthly Payment Date, the Monthly Deduction.

We credit interest to the Fixed Accumulated Value on a daily basis at the end of each day, using a 365-day year, at a rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. At our discretion, we may credit additional interest. Any such additional interest may be adjusted to reflect expenses, taxes, profit, or sources of earnings other than investment earnings and will be applied uniformly to all members of the same Class. Once credited, the additional interest is nonforfeitable except indirectly due to the Surrender Charge.

POLICY CHARGES

Monthly Deduction – The Monthly Deduction provides coverage for the policy month following the Monthly Payment Date and is deducted from the Accumulated Value on each such date before the Monthly Deduction End Date. It is equal to the sum of the following items:

- The Cost of Insurance Charge;
- The Coverage Charge; and
- Rider charges, if any.

The maximum for each such charge is described below or in the rider forms. We may charge less than such maximum charge. Any lesser charge will apply uniformly to all members of the same Class.

Coverage Charge – This charge is based on the Face Amount of the policy and will not exceed the Maximum Monthly Coverage Charge shown in the Policy Specifications. The Coverage Charge will decrease proportionately to the Face Amount Decrease as a result of a withdrawal or payment of a Terminal Illness or rider benefit.

Rider Charges – Any rider charges are described in the rider.

Cost of Insurance Charge – The Cost of Insurance Charge is equal to (1) multiplied by (2), where:
(1) is the Monthly Cost of Insurance Rate divided by 1000 as shown in the Policy Specifications; and
(2) is the Death Benefit divided by the Net Amount at Risk Factor shown in the Policy Specifications, reduced by the Accumulated Value as of the beginning of the policy month before the Monthly Deduction is assessed.

Cost of Insurance Rates – The Maximum Monthly Cost of Insurance Rates for the initial Life Coverage are shown in the Policy Specifications.

POLICY LAPSE AND REINSTATEMENT

Grace Period – If the Accumulated Value less Policy Debt on a Monthly Payment Date is sufficient to cover the Monthly Deduction due, the policy will continue In Force. If the Accumulated Value less Policy Debt on a Monthly Payment Date is not sufficient to cover the Monthly Deduction due, a Grace Period of 61 days will be allowed for the payment of sufficient loan repayment or premium to keep your policy In Force. The Grace Period begins on the Monthly Payment Date on which the insufficiency occurred and ends 61 days thereafter. At the start of the Grace Period, we will provide a Grace Notice to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. There is no penalty for paying a premium during the Grace Period. Your policy will remain In Force during the Grace Period.

Notification of Termination for Non-Payment – Thirty days after the Monthly Payment Date on which the insufficiency occurred, we will provide a notification of termination for non-payment to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. The notice will be provided to each person at their last known addresses by first class United States mail, postage prepaid and will state the due date and the amount of loan repayment or premium required for your policy to remain In Force. A minimum of the monthly charges not deducted plus three times the monthly deduction due when the insufficiency occurred must be paid.

Lapse – If sufficient loan repayment or premium is not paid by the end of the Grace Period, a lapse will occur. If the Insured dies during the Grace Period, the Death Proceeds will be equal to the Death Proceeds as of the beginning of the Grace Period reduced by any overdue charges. Upon lapse, the policy will terminate with no value.

Reinstatement – If it has not been surrendered, this policy may be reinstated within five years after the end of the Grace Period. To reinstate this policy you must provide us with the following:

- A written application;
- Full repayment of Policy Debt, if a loan was outstanding at the time of lapse;
- Evidence of Insurability satisfactory to us; and
- Sufficient premium to cover all Monthly Deductions and Loan Interest Charges due and unpaid during the Grace Period.

The effective date of the policy reinstatement will be the Monthly Payment Date on or next following the date we approve your reinstatement application. Upon reinstatement:

- The Accumulated Value will equal the amount it was at the beginning of the Grace Period, plus the reinstatement Net Premium, less Monthly Deductions as indicated below (including those due and unpaid during the Grace Period);
- The Surrender Charges and policy charges (other than Cost of Insurance Charges) for Life Coverage under this policy will resume on their schedule as of the Monthly Payment Date when lapse occurred;
- Cost of Insurance Charges will be calculated using Cost of Insurance Rates that resume their original schedule as if lapse had never occurred, reflecting the Insured's Age at reinstatement and policy duration measured from the original Policy Date; and
- The periods during which we may exclude death by suicide and contest coverage due to a material misstatement in the reinstatement application will begin from the reinstatement date.

After the reinstatement premium has been applied, regular policy processing of Monthly Deductions will occur for the period of time when coverage was provided during the Grace Period. There will be no Monthly Deductions between the time of lapse and reinstatement.

SURRENDER AND WITHDRAWAL OF VALUES

Surrender – Upon Written Request while the policy is In Force, you may surrender this policy for its Net Cash Surrender Value. If surrendered within 30 days following a policy anniversary, the value available shall not be less than the anniversary value, less any withdrawal, Policy Loan, Terminal Illness Benefit Payment, or rider benefit paid since the policy anniversary. If surrendered at any time other than on a policy anniversary, the value available shall be calculated with allowance for lapse of time from the last preceding policy anniversary. The policy will terminate on the date the Written Request is received at our Administrative Office. The policy cannot be surrendered during the Grace Period.

Net Cash Surrender Value – The Net Cash Surrender Value is the Cash Surrender Value less any Policy Debt.

Life Return of Premium Benefit – The Life Return of Premium Benefit is equal to the Life Coverage Premium Amount at issue, as shown in the Policy Specifications.

Return of Premium Benefit – The Return of Premium Benefit is not available if your policy was issued upon the exercise of a conversion option from another policy. Otherwise, the Return of Premium Benefit, if greater than the Accumulation Value less any Surrender Charge, is available upon surrender of the policy. The Return of Premium Benefit is equal to the sum of the Life Return of Premium Benefit and any Return of Premium Benefit under riders attached to the policy. There are no increases to the Return of Premium Benefit after issue, even if additional premiums are paid.

After issue, the Return of Premium Benefit is reduced by the following events:
- Any withdrawals;
- The Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy; and
- Any benefit payments made under the riders.

These events will reduce the Life Return of Premium Benefit first (but not below zero), and then any Return of Premium Benefit under riders attached to the policy.

Cash Surrender Value – The Cash Surrender Value is equal to the greater of:
- The Accumulated Value less any Surrender Charge; or
- The Return of Premium Benefit.

Surrender Charge – If you surrender this policy, there may be a Surrender Charge deducted from the Accumulated Value. During the Level Period, the Surrender Charge is equal to the Initial Amount. After the Level Period, the Surrender Charge decreases by the Reduction Factor for the remaining Surrender

Charge Period. The Initial Amount, Level Period, Reduction Factor and Surrender Charge Period are shown in the Policy Specifications.

Withdrawals – Upon Written Request on or after the first policy anniversary, you may withdraw a portion of the Net Cash Surrender Value of this policy. Such withdrawal will be deducted from the Accumulated Value. There is no Surrender Charge imposed for a withdrawal, even if the Face Amount is reduced as a result of the withdrawal. Withdrawals may be restricted or prohibited by certain riders attached to the policy. Withdrawals will be subject to the following conditions:

- The amount of each withdrawal must be at least $200;
- The Net Accumulated Value less any Surrender Charge remaining after a withdrawal must be at least $500; and
- The Face Amount remaining after the withdrawal must be at least $50,000.

A withdrawal will reduce the Face Amount in proportion to the amount of the withdrawal divided by the Accumulation Value before the withdrawal. If such a reduction in Face Amount would cause the policy to become a Modified Endowment Contract, we will not process your withdrawal request unless and until we receive your Written Request to have your policy classified as a Modified Endowment Contract. Refer to the Premiums section for details.

If the Insured dies after the request for a withdrawal is received by us and prior to the withdrawal being processed, the withdrawal, if allowed under this provision, will be processed and paid to the Owner, or to the Owner's estate, before the Death Proceeds are determined and paid to the beneficiary.

INCOME BENEFITS

Income Benefits – All or part of any policy proceeds may, instead of being paid in a lump sum, be left with us under any one, or a combination of the income benefit plans available, subject to our minimum amount requirements on the date of election. If the payee is not a natural person, the choice of a payment option will be subject to our approval. We guarantee that the income benefit will not be less than the income that would be provided by the immediate annuity purchase rates we offer at the time. We guarantee that we will have at least the following income benefit plans available.

Fixed Income – Equal payments of the amount chosen with interest of not less than 2% per year until the funds left on deposit are exhausted.

Life Income – Monthly income will automatically be guaranteed to continue for at least ten years. If the payee dies before the end of the ten-year period, payments will continue to the end of the ten-year period to a person designated in writing by that payee. The purchase rates for the monthly income for a male or female income recipient bought by each $1,000 of benefits are shown below.

Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income
0-30	2.38	40	2.63	50	3.00	60	3.60	70	4.63
32	2.42	42	2.69	52	3.10	62	3.76	72	4.92
34	2.47	44	2.76	54	3.20	64	3.94	74	5.26
36	2.52	46	2.83	56	3.32	66	4.14	75+	5.45
38	2.57	48	2.91	58	3.45	68	4.37		

Monthly income amounts for ages not shown are halfway between the two amounts for the nearest two ages that are shown. Amounts shown are based on an annual interest rate of 2% and the Annuity 2000 female mortality table with five-year age setback. We may require evidence of survival for incomes that last more than ten years.

POLICY LOANS

Policy Loans – You may obtain policy loans by Written Request after the Free Look Period, on the sole security of the Loan Account of this policy. We recommend you consult your tax advisor before requesting a policy loan.

Loan Amount Available – The amount of the loan must be at least $200. The maximum amount available for a loan on any date is equal to the Accumulated Value less:

- Three times the most recent Monthly Deduction;
- Any Surrender Charge; and
- Any existing Policy Debt.

Loan Account – The amount of any Policy Loan will be added to the Loan Account.

Loan Repayment – You may make loan repayments at any time prior to lapse of this policy. Any payment we receive from you while you have a loan will be treated as a loan repayment, unless you tell us by Written Request that it is a premium payment.

Loan Interest Charge – Interest will accrue daily based on the balance in the Loan Account and will be due on each policy anniversary. Such interest is calculated using the simple interest method and is based on the balance in the Loan Account, using an annual interest rate of 5.50%. The corresponding daily interest rate is equal to the annual rate divided by 365. If the policy terminates before a policy anniversary, the Loan Interest Charge will be due at such time.

Policy Debt – The Policy Debt is the amount necessary to repay the Policy Loan in full and is equal to the Loan Account plus any Loan Interest Charge. The Policy Debt reduces any amount otherwise payable under the policy.

Loan Account Value – The Loan Account Value is a portion of the Accumulated Value set aside to secure the Policy Debt. The Loan Account Value is equal to the Loan Account plus Loan Interest. Such interest is based on the balance in the Loan Account, and accrues daily on a simple interest basis, using the Loan Account Interest rate, which is an annual interest rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. The corresponding daily interest rate is equal to the annual rate divided by 365.

Loan Processing on Policy Anniversary – On each policy anniversary we will adjust the values of the Policy Debt, Loan Account and Loan Account Value so that they are equal to each other. To do this, we calculate the difference between the Policy Debt and the Loan Account Value. If the Policy Debt is greater than the Loan Account Value, which is generally the case when the policy loan interest has not been paid, a new loan will be taken for the excess and will be added to the Loan Account. If the Loan Account Value is greater than the Policy Debt, which is generally the case when the policy loan interest has been paid, the excess will be transferred into the Fixed Accumulated Value.

OWNER AND BENEFICIARY

Owner – The Owner of this policy is as shown in the Policy Specifications or as later changed by Written Request. If you change the Owner, the change is effective on the date the Written Request is signed, unless otherwise specified by the Owner, subject to our receipt of it and subject to any action taken or payment made by us prior to its receipt. If there are two or more Owners, they will own this contract as joint tenants with right of survivorship, unless otherwise provided by Written Request. We recommend you consult your tax advisor before requesting a change of Owner.

Assignment – You may assign this policy by Written Request. An assignment must be recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed, unless otherwise specified by the Owner. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be

responsible for the validity of any assignment. We recommend you consult your tax advisor before requesting an assignment.

Beneficiary – The beneficiary is named by you in the Application to receive the Death Proceeds. You may name one or more beneficiaries. If you name more than one beneficiary, they will share the Death Proceeds equally or as you may otherwise specify by Written Request. If you have named a contingent beneficiary, that person becomes the beneficiary if the beneficiary dies before the Insured. A beneficiary may not, on or after the Insured's death, assign, transfer or encumber any benefit payable. To the extent allowed by law, policy benefits will not be subject to the claims of any creditor of any beneficiary.

You may make a change of beneficiary by Written Request on a form provided by us while the policy is In Force. The change will take place as of the date the request is signed, unless otherwise specified by the Owner. Any rights created by the change will be subject to any payments made or actions taken by us before we have received the Written Request.

The interest of a beneficiary who does not outlive the Insured will be divided pro rata among the surviving beneficiaries. If no beneficiaries survive to receive payment, the death proceeds will pass to the Owner, or the Owner's estate if the Owner does not survive the Insured. In the event of a simultaneous death of the Insured and a beneficiary such that it cannot be determined who died first, it will be assumed, unless proof to the contrary is provided, that the beneficiary died last.

GENERAL PROVISIONS

Entire Contract – This policy is a contract between you and us. This policy, the attached copy of the initial Application, including any amendments and endorsements to the Application, any applications for reinstatement, any endorsements, benefits, or riders, and all additional policy information sections added to this policy are the entire contract. Only our president, chief executive officer or secretary is authorized to change this contract or extend the time for paying premiums. Any such change must be in writing.

All statements in the Application shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or defend a claim on grounds of misrepresentation unless the statement is in an Application.

Incontestability – We will not contest this policy unless there was a material misrepresentation in the Application. We will rescind the policy if:

- The policy has been In Force for less than six months and we determine that the Application contains a misrepresentation that is material to acceptance for coverage; and
- The policy has been In Force for at least six months but less than two years and we determine that the Application contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy, we will return to you the premiums paid less any policy loans, any withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. No Death Benefit will be paid. This policy cannot be contested, except as provided below, after it has been In Force for two years during the Insured's lifetime.

If this policy lapses and is later reinstated, we will rescind the policy as of the reinstatement date if:

- Less than six months after the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the reinstatement date but less than two years from the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy following reinstatement, we will return to you the premiums paid after the reinstatement date less any policy loans and any withdrawals taken after the reinstatement date. No Death Benefit will be paid. We will not contest the reinstated policy after it has been In Force for two years following such reinstatement during the Insured's lifetime.

If there has been a change to the policy for which we required the Insured to submit Evidence of Insurability, we will rescind the policy change and all policy charges made after the change will be reversed and corrected charges applied so that the policy's Accumulated Value will be unaffected by the change if:

- Less than six months after the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the change but less than two years from the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

Any Death Benefits or other benefits that become payable will be determined as though the policy change had never been requested. We will not contest any such change after two years following the effective date of the change during the Insured's lifetime.

Non-Participating – This policy will not share in any of our surplus earnings.

Suicide Exclusion – If the Insured dies by suicide, while sane or insane, within two years of the Policy Date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid, less the sum of any policy loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy.

Misstatement – If the Insured's sex or birth date is misstated in the Application and it is discovered on or after the death of the Insured, the Death Benefit shall be the minimum Death Benefit for the correct sex and birth date, or if greater, a Death Benefit based on a Net Amount at Risk adjusted by the ratio of the incorrect Cost of Insurance Rate to the correct Cost of Insurance Rate. The adjusted Net Amount at Risk will result in an adjusted Death Benefit, since the Death Benefit depends on the Net Amount at Risk.

If the Insured's sex or birth date is misstated in the Application and it is discovered before the death of the Insured, we will not recalculate the Accumulated Value using the correct sex and birth date of the Insured.

Maturity – This policy does not mature, but will continue In Force so long as the Insured is alive and the policy has not been surrendered and lapse has not occurred.

After the Monthly Deduction End Date – Provided the policy is still In Force, coverage will continue on and after the Monthly Deduction End Date, subject to all policy provisions, with these exceptions and clarifications:

- Monthly Deductions will cease;
- Premiums will not be accepted, except amounts required to keep the policy in force;
- Loans will be allowed;
- Loan repayments will be permitted;
- Loan interest will continue to accrue; and
- Withdrawals will not be allowed.

Timing of Payments – We may defer payments of any Net Cash Surrender Value, withdrawal or loan (except for loans to pay a premium on any policy issued by us) for up to six months after we receive your request. If we defer any such payment for more than 30 days after we receive your request, we will pay interest at least equal to the Guaranteed Annual Interest Rate shown in the Policy Specifications.

Annual Report – A report will be mailed to your last known address no less frequently than annually. This report will show:

- The beginning and end dates of the reporting period;
- The Accumulated Value at the beginning and end of the reporting period;
- Amounts that have been credited or debited to the Accumulated Value during the reporting period, identified by type;
- The Death Benefit at the end of the reporting period;
- The Net Cash Surrender Value at the end of the reporting period;
- A notice if the Net Cash Surrender Value will not be sufficient to keep the policy in force until the end of the next reporting period, unless further premium payments are made;
- Any Policy Debt outstanding at the end of the reporting period; and
- Any other information required by law.

Additional Report – Each year, you may request, without charge, an additional report showing the same information as the Annual Report.

Basis of Values – All nonforfeiture values for this policy will be at least equal to the minimums required by the state in which this policy was delivered. Cash Values and nonforfeiture benefits available under this policy are not less than the minimum values and benefits required by or pursuant to the law of the state where the policy was delivered. To calculate the minimum required nonforfeiture values, we use the Guaranteed Annual Interest Rate shown in the Policy Specifications and mortality rates from the 2001 CSO mortality tables using age last birthday. The rates we use are both smoker and sex distinct.

Tax Qualification as Life Insurance – This policy is intended to qualify as a life insurance contract for federal tax purposes, and the Death Benefit under this policy is intended to qualify for federal income tax exclusion. The policy, including any rider, benefit or endorsement that does not specifically override this tax qualification provision, shall be interpreted to ensure and maintain such tax qualification, despite any other provision to the contrary. At no time shall the amount of Death Benefit under this policy ever be less than the minimum amount needed to ensure or maintain such tax qualification. If need be, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary to accomplish that purpose. In addition, the Accumulated Value will be reduced to reflect the increased Monthly Deductions that result from such Death Benefit increase(s), starting on the date that each increase is effective. **As of the effective date of the filing of this policy in the state in which it was delivered, the Internal Revenue Service has not published final guidance on all aspects of the tax treatment of life insurance policies that continue coverage beyond Age 100. You should consult your tax advisor, as there may be tax consequences**.

If you request a withdrawal that causes a decrease in policy or rider benefits, it may cause a reduction in any applicable tax limits on premiums or Accumulated Value for the policy to maintain such tax qualification. Such a reduction in these limits may require us to make a distribution from the policy equal to the greatest amount by which the premiums paid or Accumulated Value for the policy exceed any such reduced limits, as determined under federal tax law, in order to maintain the policy's tax qualification. If such a distribution is made, the distribution will be paid to you and the Accumulated Value will be reduced by the amount of the distribution. However, no request for a withdrawal that causes a decrease in policy or rider benefits will be allowed to the extent that we determine that the resulting reduction in such tax limits would require us to distribute more than the Net Cash Surrender Value for the policy.

Modified Endowment Contract Tax Status – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract ("MEC") as of the Policy Date. If, at the time your policy is issued, we have classified it as a MEC, this will be indicated on the Policy Specifications. Otherwise, unless and until you have given us a Written Request to accept a MEC classification for your policy, the provisions of this Modified Endowment Contract Tax Status subsection apply to your policy.

Under federal tax law, if the funding of a life insurance contract occurs too rapidly, it becomes a MEC and fails to qualify for certain favorable tax treatment as a result. This policy is intended to qualify as a life insurance contract that is not a MEC for federal tax purposes. To achieve these purposes, the provisions

of this policy (including any rider or endorsement that does not specifically override this tax qualification provision) shall be interpreted to prevent this policy from being subject to such MEC treatment, despite any other provision to the contrary. If and while the provisions of this subsection apply to your policy, the amount of Death Benefit under this policy shall never be less than the minimum amount needed to avoid such MEC treatment.

We will not accept a payment as premium or otherwise which would cause the policy to become a MEC. The 7-Pay Premium, shown on Page 3.0, is used solely to determine the policy's premium limits to avoid MEC treatment. Payment of one or more 7-Pay Premium amounts does not guarantee that the policy will never lapse, and additional premiums may be necessary to prevent the policy from lapsing in the future.

If at any time the amounts paid under the policy exceed the limit for avoiding such MEC treatment, this excess amount, including any interest as determined under federal tax law, shall be removed from the policy as of the date of its payment, and any appropriate adjustment in the Death Benefit and/or Accumulated Value shall be made as of such date. This excess amount, including any interest, shall be refunded no later than 60 days after the end of the applicable contract year, as determined under federal tax law.

If this excess amount is not refunded by the end of such 60-day period, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary (e.g., to the end of any MEC 7-year test period) so that at no time is the Death Benefit ever less than the minimum amount necessary to avoid Modified Endowment Contract classification. In addition, the Accumulated Value will be reduced to reflect any increased Monthly Deductions resulting from such Death Benefit increase, starting on the date that the increase is effective.

Any request that would change the Death Benefit or any other benefit or rider under the policy will not be processed if the change would cause the policy to be classified as a Modified Endowment Contract. Requested changes that could cause the policy to be classified as a Modified Endowment Contract include, but are not limited to a withdrawal that would cause a reduction in the Face Amount.

Other Distributions of Accumulated Value – If the Net Amount at Risk ever exceeds three times the original Face Amount, we reserve the right to make a distribution of Accumulated Value to make the Net Amount at Risk equal three times the original Face Amount. In such case, the distribution will be treated as a premium refund. Note that while such a distribution will be treated as a premium refund for certain contract purposes, normal tax rules will apply in determining the amount of such a distribution, if any, which is taxable.

Additional Services – While this policy is In Force, we may, either directly or through a third party service provider, provide you with access to independent living-related resources and discounted independent living-related goods and services.

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PACIFIC LIFE

Pacific Life Insurance Company, 45 Enterprise, Aliso Viejo, CA 92656

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Proceeds Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**
- **Terminal Illness Benefit (Accelerated Death Benefit)**

P11PPC

ACCELERATED BENEFIT RIDER ("ABR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider accelerates the Policy's benefits by reimbursing the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy and this Rider are received to examine and return both of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and this Rider, but both must be returned together. The Policy and Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for both the Policy and this Rider within 30 days of such a Policy and Rider return and the Policy and Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy. Defined terms are usually capitalized to show emphasis.

ABR Benefit Duration – The period of coverage under this Rider. The ABR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The ABR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that has the appropriate state licensure or certification as an Assisted Living Facility where required. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;

- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- Performance of comprehensive individualized Assessments, including reassessments as needed;
- Development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in the Insured's condition, by a Care Coordinator; and
- Coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by the Insured or Representative and determined necessary by the Care Coordinator.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under this Rider. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or experience to provide such care. If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:

- Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and

- Provide ongoing supervision and training to its employees appropriate to the services to be provided.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

In Force – means that this Rider is in effect.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum ABR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum ABR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum ABR Benefit Limit will be reduced when:

- A payment of benefit is made in accordance with the terms of this Rider;

- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum ABR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit, International Benefit and Alternative Care Benefit. The initial Monthly Maximum ABR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will be reduced when:

- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;

- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- The Insured's functional or cognitive abilities;
- The Insured's social situation; and
- The Insured's care service needs.

Policy – means the life insurance policy to which this Rider is attached.

Policy Date – means the date the Policy and this Rider become effective.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative – means a person or entity legally empowered to represent the Insured.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Spouse – means the person to whom the Insured is legally married or the Insured's partner in a civil union or domestic partnership.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The applicable Elimination Period has been satisfied;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum ABR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

The Owner must elect to accelerate benefits under the Policy by making a claim for benefits under this Rider.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Elimination Period – The applicable Elimination Period must be completed before benefits are payable. The Policy Specifications show the number of days for the Elimination Period.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum ABR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum ABR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit;
- Alternative Care Benefit; and
- International Benefit.

CARE COORDINATION

Care Coordination – Care Coordination helps the Insured identify his specific care needs and the long-term care services and programs in his area that can best meet those needs. The Insured may use a Care Coordinator to help him make the most informed decision regarding his care.

About Care Coordination – Care Coordination provides the Insured with the knowledge and training of a Care Coordinator who will review his unique situation and develop Plans of Care to meet his needs. The Care Coordinator, a Licensed Health Care Practitioner, will:

- Assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis;
- Work with the Insured to determine the specific services required;
- Develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the needs of the Insured;
- Coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and
- Help the Insured arrange for care, if desired.

Care Coordination is Voluntary – Care Coordination is advisory only. The Insured is not required to use Care Coordination to arrange for care providers or to use the specific care providers identified in the Plan of Care. However, all the Insured's Rider benefits must be provided in accordance with an approved Plan of Care.

Limited Availability Outside United States – Care Coordination other than performing an Assessment or developing a Plan of Care is not available for care received outside the United States.

Transition Planning – If the Insured desires, the Care Coordination Provider will recommend a transition plan that specifies how the Insured's care needs may be met once:

- The Insured has exhausted the benefits under his Rider; or
- The Insured is no longer a Chronically Ill Individual but needs some continued level of assistance.

Care Coordination Provided by Us – Care Coordination provided by us does not require a claim for benefits under this Rider. Any Care Coordination provided by us will not reduce the Maximum ABR Benefit Limit or the Monthly Maximum ABR Benefit Amount.

CARE COORDINATION BENEFIT

Care Coordination Benefit – Benefits are payable for Covered Expenses for Care Coordination that is not performed by us. The Covered Expenses and the amount of the benefit we pay are described below.

Covered Expenses – Covered Expenses for Care Coordination means expenses the Insured incurs, while the Insured is a Chronically Ill Individual, for Care Coordination that is not performed by us.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Care Coordination during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NURSING HOME BENEFIT

Nursing Home Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in a Nursing Home Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for a Nursing Home Facility means expenses the Insured incurs during his Confinement in a Nursing Home Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Nursing Home Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Nursing Home Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Nursing Home Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses also include fees charged for Hospice Care provided by a Hospice Care Facility.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

ASSISTED LIVING FACILITY BENEFIT

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in an Assisted Living Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for an Assisted Living Facility means expenses the Insured incurs during his Confinement in an Assisted Living Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Assisted Living Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Assisted Living Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Assisted Living Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured was a Chronically Ill Individual and incurring Covered Expenses during the month.

HOME AND COMMUNITY CARE BENEFIT

Home And Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for Home and Community Care means fees charged for the following services when provided to the Insured by a Home Health Care Agency:

- Home Health Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care and Respite Care.

Covered Expenses also includes fees charged for Adult Day Care provided by an Adult Day Care Center.

Criteria for Receiving Care from an Independent Provider – The Independent Provider must be licensed or certified in the state where the care will be provided, if licensing or certification is required for the services provided. An Independent Provider must present written proof of completion of an established training course or written proof of licensure or certification. The education must include training in safely assisting persons with all Activities of Daily Living. We will accept as proper credentials the Independent Provider's inclusion in a government-sponsored nurse aide registry. If the state in which the Insured lives does not require or accept licensure or certification for Independent Providers, then we may approve benefits for an Independent Provider if we can determine that the individual is qualified by training and experience to provide Home Health Care Services and Maintenance or Personal Care Services.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care during the policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

INTERNATIONAL BENEFIT

International Benefit – The Insured is eligible to receive cash benefits when Confined in a Nursing Home Facility outside the United States. The conditions under which we will pay this International Benefit and the amount of benefit payable are described below.

Conditions for International Benefits – This cash benefit will be available beginning on the day the Insured first satisfies the Eligibility for the Payment of Benefits requirements and is Confined in a Nursing Home Facility outside the United States. This benefit is in lieu of all other benefits under this Rider.

The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and Confined in a Nursing Home Facility outside the United States. For proof that the Insured is Confined in a Nursing Home Facility outside the United States, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. Proof that the Insured is a Chronically Ill Individual must be provided every 90 days. The cost for providing any of the proof required for this benefit is the responsibility of the Owner.

The Insured must notify us in advance to receive benefits under this provision. The notice must be made in writing and in English. If we are not notified prior to the date of admission to the Nursing Home Facility, then the first date the Insured is eligible for this benefit is the date we receive satisfactory written notice of an eligible Nursing Home Facility stay.

The International Benefit will end at the earliest of the date on which the Insured:

- Has received the Maximum ABR Benefit Limit;
- Is no longer a Chronically Ill Individual;
- Is no longer Confined in a Nursing Home Facility; or
- Returns to the United States.

No other benefit under this Rider is payable during a Policy month for which the Insured receives the International Benefit.

If the Insured is currently in claim in the United States, the Insured cannot leave the United States and be eligible for the International Benefit.

How Much We Will Pay – Benefits are payable for each month that the Insured meets the Conditions for International Benefits. We will pay the Monthly Maximum Benefit ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and Confined in a Nursing Home Facility each day of the Policy month, the benefit for the month will be pro-rated. It will consist of 1/30 of the Insured's Monthly Maximum Benefit ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual during the month.

All benefit payments will be made in U.S. dollars.

ALTERNATIVE CARE BENEFIT

Alternative Care Benefit (For expenses not otherwise covered, but authorized by us) **–** We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in this Rider.

Covered Expenses – Benefits and services can be authorized if we determine that they:

- Are cost-effective;
- Are appropriate to the Insured's needs;
- Are consistent with general standards of care;
- Provide the Insured with an equal or greater quality of care; and
- Are for and constitute Qualified Long-Term Care Services.

Any benefits, treatments, or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician.

We reserve the right to decline to authorize benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once the Insured has exhausted the benefits under this Rider. Agreement to participate in Alternative Care Benefits will not waive any of the rights the Insured or we have under this Rider.

Alternative Care Benefits may be discontinued at any time without affecting the Insured's right to the benefits otherwise available under this Rider.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NON-CONTINUAL ALTERNATIVE CARE BENEFIT

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Non-Continual Alternative Care Benefits. The amount of the benefit we will pay and the conditions under which we will pay this benefit are described below.

Covered Expenses – Covered Expenses for the Non-Continual Alternative Care Benefit means Covered Expenses the Insured incurs for the following, as described below:

- Home Modification; and
- Durable Medical Equipment.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Our determination of whether the Home Modification is a cost-effective alternative will occur within a reasonable period of time. Benefits are not payable for any expenses incurred prior to the date of agreement between the Owner, the Insured, and us. Agreement to participate in Home Modification under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Rider.

Covered Home Modification Expenses – Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to the Insured's Home is a cost-effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance his ability to perform the Activities of Daily Living and allow the Insured to remain in his or her Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the

Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Durable Medical Equipment under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. The Durable Medical Equipment must be located in the Insured's Home.

Covered Durable Medical Equipment Expenses – Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in the Insured's Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment. This benefit is subject to the Non-Continual Alternative Care Benefit Lifetime Maximum shown on the Policy Specifications.

CAREGIVER TRAINING BENEFIT

Caregiver Training Benefit – Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in his or her Home.

Covered Expenses – Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return Home, where the Insured can be cared for by the person receiving the training.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Caregiver Training. This benefit is subject to the Caregiver Training Benefit Lifetime Maximum shown on the Policy Specifications.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is the Monthly Maximum ABR Benefit Amount applicable on the Policy Date, adjusted for withdrawals and for benefits paid under the Terminal Illness Benefit; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times (B divided by C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is the new Monthly Maximum ABR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum ABR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request; or
- The date the Maximum ABR Benefit Limit has been paid.

ABR RETURN OF PREMIUM BENEFIT

ABR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the ABR Return of Premium Benefit is equal to the ABR Premium, as shown on the Policy Specifications. After issue, the ABR Return of Premium Benefit may be reduced (but not below zero) as described in the Policy, after the reduction of the Life Return of Premium Benefit.

EFFECT OF RIDER ON POLICY

Effect of Benefit Payment Under This Rider on Death Proceeds – We reserve the right to withhold any portion of the Death Proceeds that would otherwise be payable for a reasonable period of time under the facts and circumstances to allow verification that we have received all remaining claims for Covered Expenses incurred before the date of death of the Insured.

Effect of Benefit Payment Under This Rider on Policy Withdrawals – Once a claim for benefit payment under this Rider has been received by us, no withdrawals may be made under the Policy.

Effect of Benefit Payment Under This Rider on Policy's Face Amount – Benefit payment under this Rider will reduce the Policy's Face Amount. The reduction in the Policy's Face Amount after payment of the benefit is calculated as A times the result of (B divided by C) where:

A. Is the Policy's Face Amount prior to payment of the benefit;
B. Is the benefit payment; and
C. Is the Maximum ABR Benefit Limit before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Accumulated Value – Benefit payment under this Rider will reduce the Policy's Accumulated Value. The Policy's Accumulated Value after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Policy's Accumulated Value prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy Debt – If there is a loan outstanding under the Policy at the time a benefit under this Rider is payable, a portion of the benefit will be applied towards repayment of the loan. The amount of the benefit that will be allocated as a loan repayment will be calculated as A times the result of (one minus (B divided by C)) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

The Policy Debt after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Coverage Charge – Benefit payment under this Rider will reduce the Policy's Coverage Charge. The Coverage Charge after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Coverage Charge prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

EFFECT OF POLICY ON RIDER

Effect of Withdrawals on This Rider – Any withdrawal made under the Policy will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

The new Maximum ABR Benefit Limit after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

Effect of Terminal Illness Benefit Payment on this Rider – Any amount paid under the Terminal Illness Benefit will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

The new Maximum ABR Benefit Limit after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

EXCLUSIONS AND LIMITATIONS

Benefits under this Rider will not be limited or excluded by type of illness, treatment, medical condition or accident, except as provided in this section. In this section, we state the conditions under which payment will be limited, or not made at all, even if the Insured otherwise qualifies for benefits. These conditions apply to all benefits provided by this Rider.

Exclusions – This Rider will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - He or she is a regular employee of an organization which is providing the treatment, service or care; and
  - The organization receives the payment for the treatment, service or care;
- Care or services for which no charge is made in the absence of insurance;
- Care or services provided outside the United States of America, except as provided for under the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while this Rider is not In Force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion – We will not reduce or deny any claim under this Rider because of a sickness or physical or medical condition disclosed on the Application.

CLAIMS PROVISIONS

In this section, we describe when we must be notified of a claim; what to send us; how we evaluate and pay claims; and other rights and responsibilities under the Rider.

The Insured's Role in the Claims Process – Early awareness by us will facilitate a timely claim review. It is important that the Owner or Insured notify us immediately when the Owner or Insured thinks the Insured is eligible for benefits under this Rider. To file a claim, the Owner or Insured may call us, notify us in writing or submit a completed claim form we provide.

Notify Us as Soon As Possible – We can handle the claim request more efficiently if we are notified within 30 days after the Insured is eligible for benefits or as soon as reasonably possible. We prefer to be notified as soon as the Insured first becomes disabled to the extent that the Insured may soon need care covered by this Rider. Notify us even if the Owner or Insured is unsure, and we can help determine whether the Insured is eligible for benefits.

How Claims Are Evaluated – When notice of claim is received, we will collect the information we need to verify whether the Eligibility for the Payment of Benefits requirements have been met. We may need to contact the Insured's Physician or other care provider and to review the Insured's medical records. Based on our evaluation of this information, we will verify the Insured's eligibility for benefits. We will not pay benefits until we verify eligibility for benefits. If we determine that the Insured is eligible for benefits, we will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordinator.

Cross Border Rules – Benefits will be paid for similar services obtained in a state other than the Policy state of issue if benefits for those services would have been paid in the Policy state of issue, irrespective of any facility licensing, certification or registration requirement (or similar requirements) differences between the states.

Claim Forms – We will provide claim forms for the filing of proofs of loss when we receive the notice of claim. If the Owner, Insured or Insured's Representative does not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending us a letter which describes the occurrence, the character and the extent of the loss for which the claim is made. That letter must be sent to us at our Administrative Office within the time noted below under Proof of Loss.

Proof of Loss – In the case of a claim for continuing loss for which this Rider provides any periodic benefits, written proof of loss must be given to us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be given to us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than one year after the date the proof is otherwise required.

Written Notification – The Owner will be notified in writing whether or not the Insured is eligible for benefits. We will provide notification within ten days of receiving all the required information. If the Owner wants to receive information related to a denial of benefits, that information will be sent to the Owner within 60 days of receipt of his or her written request, or as required by the applicable laws and regulations where the policy is delivered or issued for delivery.

When Benefit Payments Will Be Made – Once the applicable Elimination Period has been completed, benefit payments will be made upon our receipt of the required written claims and evidence of the Insured's continued eligibility. Benefit payments will be made as long as the loss and our liability continue. When a claim is paid, the Owner will receive an Explanation of Benefits from our Administrative Office.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner unless otherwise assigned. Any benefits to which the Owner is entitled that are unpaid at the Insured's death will be payable to the Owner. If benefits are payable to an estate, we may pay a portion of those benefits, up to $5,000, directly to the Owner's spouse or someone related to the Owner by blood or marriage who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examination – At our expense, we have the right to require an examination of the Insured's functional or cognitive status when a claim is made and at reasonable intervals while benefits are being claimed.

How the Owner or Insured Can Appeal a Claim Decision – If the Owner or Insured disagrees with our decision regarding a claim, the Owner may request in writing within 60 days of that decision that we reconsider the claim. Any internal review of claim decisions will be consistent with the applicable laws and regulations where the policy is delivered or issued for delivery. The Owner or Insured should submit any additional information that the Owner or Insured feels we need to review our decision. The Owner or Insured should include the names, addresses, and phone numbers of any care providers we should contact to learn more about the loss. The Owner is responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider our decision and send written notification of the results to the Owner. If we deny the appeal request and the Owner wants to receive written information related to such denial, that information will be sent within 60 days of receipt of the written appeal request. This Rider will comply with any requirements regarding external review of claim decisions, consistent with the applicable laws and regulations where the policy is delivered or issued for delivery.

Legal Actions – No action may be brought to recover under this Rider until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given. Any legal cause of action shall conform to the laws of the state in which the policy was delivered or issued for delivery.

Direct Payment of Benefits to Care Provider (Assignment of Benefits) – The Owner may instruct us to pay benefits due under this coverage directly to a Nursing Home Facility, Assisted Living Facility, Hospice Care Facility, Adult Day Care Center or Home Health Care Agency providing the care for which we are reimbursing expenses. The care provider must also agree to the assignment of benefits. The Owner must notify us by Written Request. An assignment will take place only when recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed, unless otherwise specified by the Owner. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of any assignment.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

In this section, we describe such things as the premium for this Rider and the reinstatement provisions.

Non-Cancellable – This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision. The premiums under this Rider are paid by a single premium on or before the Policy Date and cannot be increased.

Paying Premiums, Single Premium – In order for this Rider to be In Force, a single premium covering the entire cost of the Rider must have been paid to us on or before the Policy Date.

Protection Against Unintentional Lapse – In order to protect the Policy and Rider against unintentional lapse, at least one person in addition to the Owner must be designated to receive notice of lapse or termination or the Owner must sign a waiver electing not to designate an additional person to receive notice. The Owner may change this designation at any time. To do so, notify us in writing. We will remind the Owner in writing every two years of this opportunity.

Grace Period – The Grace Period provision in the Policy applies to this Rider.

Notification of Non-Payment – The Notification of Non-Payment provision in the Policy applies to this Rider.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any ABR Return of Premium Benefit.

Reinstatement – If the Policy is reinstated under its Reinstatement provision, this Rider is also eligible to be reinstated provided that such reinstatement occurs within six months from the end of the Grace Period. After the six-month period, this Rider will not be reinstated, even if the Policy is reinstated.

Added Protection Against Lapse – If coverage terminates due to lapse, we will provide a reinstatement of coverage as specified below, if certain conditions are met. To be eligible for this reinstatement, the Insured must provide us proof that the Insured was a Chronically Ill Individual, beginning on or before the date of termination.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner that demonstrates that the Insured was a Chronically Ill Individual. The proof must be provided to us within five months of the termination date. The Owner must pay all past due premiums and outstanding Policy Debt prior to the date of lapse. In that event, the Policy and this Rider will be reinstated as of the date of that termination without interruption of insurance for that period.

Requirements for Reinstatement – If this Rider is eligible to be reinstated, in order for us to evaluate your request for reinstatement, you must satisfy the requirements for reinstatement of the Policy and this Rider.

Reinstatement of the Policy and this Rider is effective upon our approval of your reinstatement application. If we issue a temporary insurance agreement in connection with the premium tendered for reinstatement, and we do not act to approve the application, the reinstatement is effective on the 45th day following the date of the temporary insurance agreement unless we have given notice to the Owner of our disapproval of the application prior to the expiration of the 45 day time limit.

If approved, the Policy and this Rider will be reinstated retroactive to the date of termination of coverage. In all other respects, including benefits for Covered Expenses, the Owner will have the same rights under this Rider as prior to the termination. Any amount refunded due to lapse in connection with the ABR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request;
- The date the Maximum ABR Benefit Limit has been paid; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility before the date of termination in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Elimination Period and Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy and Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

QUALIFIED LONG-TERM CARE SERVICES

Benefit for Qualified Long-Term Care Services – This Rider provides benefits for Qualified Long-Term Care Services received by a Chronically Ill Individual provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. Benefits for Qualified Long-Term Care Services are conditioned on a determination that the Insured is a Chronically Ill Individual.

Certification by A Licensed Health Care Practitioner – Certification that the Insured is a Chronically Ill Individual shall be performed by a Licensed Health Care Practitioner. Such certifications may be performed by a Licensed Health Care Practitioner at our direction as is reasonably necessary with respect to a specific claim, except that when a Licensed Health Care Practitioner has certified that the Insured is a Chronically Ill Individual and the Owner or Insured has made a claim for benefits under this Rider, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period starting on the date of certification.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable to what the premium paid would have purchased at the Insured's correct sex or birth date as of the Policy Date.

Fraud/Recovery – If we determine that benefits have been paid under the Policy or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If, on or after the Policy Date, this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to always comply with those requirements. However, because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change. We will also inform the Owner that if they reject the change, the policy may no longer be tax-qualified under the Internal Revenue Code, and the Owner should consult a financial planning professional and independent tax advisor.

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EXTENDED BENEFIT RIDER ("EBR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider extends the benefits provided by the Accelerated Benefit Rider ("ABR") for Long-Term Care. The benefits of this Rider become effective after payments for Covered Expenses under the ABR have reached the Maximum ABR Benefit Limit. This Rider reimburses the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy, ABR, and this Rider are received to examine and return all of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy, ABR, and this Rider, but all must be returned together. The Policy, ABR, and this Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for the Policy, ABR, and this Rider within 30 days of such a return and the Policy, ABR, and this Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer — Secretary

[www.PacificLife.com] [(800) 347-7787]

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy or the ABR. Terms used in this Rider, the Policy and the ABR will have the same definition unless stated otherwise in this Rider. Defined terms are usually capitalized to show emphasis.

EBR Benefit Duration – The period of coverage under this Rider. The EBR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The EBR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

In Force – means that this Rider is in effect.

Maximum EBR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum EBR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum EBR Benefit Limit will be reduced when a payment of benefit is made in accordance with the terms of this Rider.

Monthly Maximum EBR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit and Alternative Care Benefit. The initial Monthly Maximum EBR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum EBR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum EBR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions – In addition to meeting the Eligibility for the Payment of Benefits criteria shown above, the following conditions must also be met in order for benefits to be paid under this Rider:

- The Owner must elect to claim benefits under this Rider; and
- The Covered Expense incurred for which benefits are claimed under this Rider must occur after the Maximum ABR Benefit Limit has been exhausted.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum EBR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum EBR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit; and
- Alternative Care Benefit.

LONG-TERM CARE BENEFITS

Long-Term Care Benefits – This Rider extends the benefits provided under the ABR by providing a Maximum EBR Benefit Limit and a Monthly Maximum EBR Benefit Amount, which become effective when the Maximum ABR Benefit Limit under the ABR is exhausted.

Specific Benefits – The specific benefits in the ABR to which this extension applies are the following:

- Care Coordination;

- The Care Coordination Benefit;
- The Nursing Home Benefit;
- The Assisted Living Facility Benefit;
- The Home and Community Care Benefit;
- The Alternative Care Benefit;
- The Non-Continual Alternative Care Benefit; and
- The Caregiver Training Benefit.

Differences from the ABR – When benefits are payable under this Rider, the benefits shown above will be paid as described in the ABR except for the following:

- References in the ABR to the Maximum ABR Benefit Limit will be considered to be references to the Maximum EBR Benefit Limit shown on the Policy Specifications;
- References in the ABR to the Maximum Monthly ABR Benefit Amount will be considered to be references to the Monthly Maximum EBR Benefit Amount;
- This Rider does not provide an International Benefit; and
- The Elimination Period does not apply to this Rider.

If benefits that are subject to the Maximum Monthly ABR Benefit Amount become payable partly under both this Rider and the ABR (because the Maximum ABR Benefit Limit has been exhausted during the month), the maximum amount payable under all such benefits is limited to the greater of:

- The Monthly Maximum ABR Benefit Amount; and
- The Monthly Maximum EBR Benefit Amount.

Benefits payable under the Non-Continual Alternative Care Benefit and the Caregiver Training Benefit of this Rider will:

- be reduced by the respective amounts for which payment is made under the ABR; and
- not be provided if the respective lifetime maximum benefit has been exhausted under the ABR.

The terms, conditions and exclusions of the ABR apply to the payment of benefits under this Rider unless otherwise stated in this Rider.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is the Monthly Maximum EBR Benefit Amount applicable on the Policy Date; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times (B divided by C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is the new Monthly Maximum EBR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum EBR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy and ABR are cancelled pursuant to the Owner's request; or
- The date the Owner has received the Maximum EBR Benefit Limit allowed.

EBR RETURN OF PREMIUM BENEFIT

EBR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the EBR Return of Premium Benefit is equal to the EBR Premium, as shown on the Policy Specifications. After issue, the EBR Return of Premium Benefit may be reduced as described in the Policy, after the reduction of the Life Return of Premium Benefit and the ABR Return of Premium Benefit.

NONFORFEITURE BENEFIT

Nonforfeiture Benefit – Upon lapse of this Rider, the Owner is eligible for one of the two options described below. The Owner can change the elected benefit at any time before lapse by sending us a Written Request. The options available are:

1. Return of Premium Benefit as described in this Rider. This option will be effective automatically unless the Owner requests otherwise in writing.
2. Shortened Benefit Period. Under this option, we will continue coverage of eligible claims until the earlier of:
    a. The death of the Insured; or
    b. The date the Nonforfeiture Benefit Limit has been reached.

Nonforfeiture Benefit Limit – is an amount equal to the greater of:
a. The Monthly Maximum EBR Benefit Amount; or
b. The EBR Premium, as shown in the Policy Specifications.

The Nonforfeiture Benefit Limit is reduced by the sum of all benefits previously paid under this Rider. The Nonforfeiture Benefit Limit will never be greater than the remaining amount payable had this Rider stayed In Force.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – This Rider will not pay benefits for any expenses incurred:

- Prior to the date the Maximum ABR Benefit Limit has been exhausted under the ABR; or
- That would have been excluded from payment under the ABR had it remained In Force (as stated in the Exclusions and Limitations provision of that rider).

CLAIMS PROVISIONS

The Claims Provisions in the ABR apply to the payment of benefits under this Rider.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

The Premiums, Lapse and Reinstatement provisions of the ABR apply to this Rider, except as modified below.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any EBR Return of Premium Benefit.

Reinstatement – If the ABR is reinstated under its Reinstatement provision, this Rider will also be reinstated. Any amount refunded due to lapse in connection with the EBR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy, the ABR and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider, the ABR and the Policy are cancelled pursuant to the Owner's request;
- The date the Owner has received the Maximum EBR Benefit Limit allowed under this Rider; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy, the ABR and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility before the date the Policy, the ABR or this Rider ended in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy, the ABR and this Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable to what the premium paid would have purchased at the Insured's correct sex or birth date as of the Policy Date.

Fraud/Recovery – If we determine that benefits have been paid under the Policy, the ABR, or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy, the ABR, or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If, on or after the Policy Date, this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to always comply with those requirements. However, because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change.

We will also inform the Owner that if they reject the change, the policy may no longer be tax-qualified under the Internal Revenue Code, and the Owner should consult a financial planning professional and independent tax advisor.

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LIMITED REFUND ON DEATH ENDORSEMENT

This endorsement becomes part of the policy to which it is attached.

Limited Refund on Death – Some of the premium paid for a rider, may be refunded on the death of the Insured. The amount of refunded premium, if any, will be equal to the greater of either zero, or A times the result of B minus C minus D minus E, where:

A. Is the number obtained after dividing:
   - The premium paid for the rider, as shown in the Policy Specifications, by
   - The total premium paid for the riders, as shown in the Policy Specifications;
B. Is the Total Premium at issue, as shown in the Policy Specifications;
C. Is the greater of the Death Benefit or the Residual Death Benefit payable under the Policy;
D. Is the sum of any benefit payments we have made under all riders; plus the Requested Portion corresponding to any Terminal Illness Benefit Payment under the Policy's Terminal Illness Benefit provision; and
E. Is the sum of all Adjusted Withdrawal Amounts.

If B minus C minus D minus E is zero or less than zero, then no premium will be refunded.

As used above, "Adjusted Withdrawal Amount" is an amount calculated separately with respect to each Withdrawal taken against the Policy, and is based upon the Policy's Face Amount and Accumulated Value immediately prior to the Withdrawal. As to each Withdrawal, the Adjusted Withdrawal Amount equals the Withdrawal amount multiplied by the Policy's Face Amount, then divided by the Policy's Accumulated Value.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

AVIATION EXCLUSION RIDER

Risks Not Covered – This policy does not cover death, disability, or chronic illness or any benefit that would be payable to a Chronically Ill Individual resulting from injuries sustained as a result of riding in, descent with or descent from an aircraft unless the deceased was a fare-paying passenger.

The amount payable under this policy in the event of death as a result of a risk not covered will be the greater of:

- Total premiums received under this policy (without interest) less any withdrawal amounts, the Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy, and any benefit payments made under the policy riders; or
- An amount equal to the Cash Surrender Value of this policy.

Any existing Policy Debt on this policy will be deducted from the amount payable. However, the total amount payable will not exceed the payment that would have been made in the absence of this rider.

General Conditions – This rider is part of the policy to which it is attached. This rider becomes effective on the Policy Date unless otherwise specified.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

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PACIFIC LIFE

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE

Rider Forms R11ABR and R11EBR

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

CAUTION: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application will be attached to any issued Policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy and Riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: [45 Enterprise, Aliso Viejo, CA 92656].

1. THIS POLICY AND THE RIDERS PROVIDE INDIVIDUAL COVERAGE

The Policy is a flexible premium adjustable life insurance policy with individual long-term care insurance Riders. If the base life insurance Policy is issued, the Accelerated Benefit Rider (ABR) will also be issued. The coverage under the ABR provides two years of long-term care insurance benefits by accelerating payment of the life insurance policy's face amount. The Extended Benefit Rider (EBR) is an optional purchase and provides between one and six years of additional long-term care benefits, depending on the duration elected. You may elect to purchase the Policy and ABR without purchasing the EBR. This outline of coverage describes both the ABR and the EBR (Riders). Capitalized terms used in this outline of coverage are defined in the Definitions section, starting on page 8.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Riders contain governing contractual provisions. This means that the Policy and Riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

These Riders are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS COVERAGE IS NONCANCELLABLE – This means you have the right, subject to the terms of your Policy and Riders, to continue your coverage as long as the single premium is paid. We cannot change any of the terms of your coverage on our own and cannot

require that you pay additional premium after the Riders are issued, including for any Inflation Benefit Option.

Waiver of Premium – A waiver of premium provision waives premium payments that become due when an insured is receiving benefits under the coverage. There is no waiver of premium for these Riders because there is a single premium required and it must be paid prior to the coverage being issued. After issue there are no further premiums required that could be waived.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We do not have the right to change the premium rates for your coverage. This coverage requires a single premium and it must be paid prior to the Policy and Riders being issued. After issue, you will not be required to make any additional premium payments.

6. TERMS UNDER WHICH THE POLICY AND RIDERS MAY BE RETURNED AND PREMIUM REFUNDED

The Owner has 30 days from the day the Policy and Riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and the Riders. The Policy and Riders can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid within 30 days of such a Policy and Rider return and the Policy and Riders will be void from the start.

Return of Premium Benefit – The Riders each include a Return of Premium Benefit that is payable if the coverage is surrendered or lapsed. At issue, the Return of Premium Benefit is equal to the premium paid for the ABR or EBR, as shown on the Policy specifications. After issue, the Return of Premium Benefit may be reduced by withdrawals, a Terminal Illness Benefit Payment (available under the terms of the Policy) or benefit payments under the Riders, as described in the Riders.

Limited Refund on Death – Some of the premium paid for the Riders may be refunded on the death of the Insured. The amount of refunded premium, if any, will be based on the premium paid for the Riders, adjusted for any death benefit payable under the Policy, benefit payments made under the Riders, Terminal Illness Benefit Payment or withdrawals, as described in the Riders.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor our producers/representatives represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home facility, in the community, or in the home.

With the exception of the International Benefit, which applies only to the ABR, this coverage provides reimbursement benefits. Reimbursement benefits reimburse the Owner for covered long-term care expenses incurred. The International Benefit under the ABR pays indemnity benefits. Indemnity benefits pay a fixed dollar amount regardless of the amount of expenses incurred. All benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE COVERAGE

Benefits are available under the ABR up to the Monthly Maximum Benefit Amount until the Maximum ABR Benefit Limit is reached. The EBR extends most of the benefits provided by the ABR, subject to the Maximum Benefit Amount, until the Maximum EBR Benefit Limit is reached. The Non-Continual Alternative Care Benefit and the Caregiver Training Benefit are subject to lifetime maximums specific to those benefits. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits for the following Covered Expenses:

Care Coordination and Care Coordination Benefit – Care Coordination is intended to help identify an Insured's specific care needs and long-term care services and programs available to meet those needs. Care Coordination will provide the Insured with a Care Coordinator who will review the Insured's specific situation and develop Plans of Care to meet the Insured's needs. The Care Coordinator will: assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis; work with the Insured to determine the specific services the Insured requires; develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs; coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and help the Insured arrange for care.

Care Coordination provided by us does not require a claim for benefits and does not count against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Care Coordination not performed by us requires a claim for Care Coordination Benefits, which counts against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Benefits are payable for Covered Expenses the Insured incurs for Care Coordination not performed by us during the Policy month up to the Monthly Maximum Benefit Amount.

Nursing Home Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in a Nursing Home Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses also include Hospice Care provided by a Hospice Care Facility. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Nursing Home Benefit will be pro-rated.

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in an Assisted Living Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Assisted Living Facility Benefit will be pro-rated.

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care, which include the following services when provided by a

Home Health Care Agency or by an Independent Provider: Home Health Care Services; Maintenance or Personal Care Services; Hospice Care; and Respite Care. Covered Expenses also include Adult Day Care provided by an Adult Day Care Center. Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Home and Community Care Benefit will be pro-rated.

International Benefit – The International Benefit is included as part of the ABR only and is not available under the EBR. The Insured is eligible to receive the full Monthly Maximum ABR Benefit Amount when Confined in a Nursing Home Facility outside the United States. No other benefit is payable under the ABR during any Policy month for which the Insured receives the International Benefit. This cash benefit will be available beginning on the date the Insured first satisfies the Eligibility for Payment of Benefits requirements and is Confined to a Nursing Home Facility outside the United States. The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and is Confined in a Nursing Home Facility outside the United States in order to receive this benefit. For proof of this, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. The Insured must provide written proof every 90 days, in English, that the Insured is a Chronically Ill Individual. The cost for providing any proof required for this benefit is the responsibility of the Owner. We must be notified in advance to receive the International Benefit and such notice must be made in writing and in English. Each month the Insured is eligible for the International Benefit, benefits are payable in the amount of the Monthly Maximum ABR Benefit Amount. If the Insured is not a Chronically Ill Individual each day of the Policy month, the International Benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

Alternative Care Benefit – We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the Riders. Benefits and services can be authorized if we determine that they: are cost-effective; are appropriate to the Insured's needs; are consistent with general standards of care; provide the Insured with an equal or greater quality of care; and are for and constitute Qualified Long-Term Care Services. Any benefits, treatments or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician. We reserve the right to decline to authorize benefits and services. Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits.

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment up to the Non-Continual Alternative Care Benefit Lifetime Maximum.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance the Insured's ability to perform the Activities of Daily Living and allow the Insured to remain in the Insured's Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits

otherwise provided by the Riders. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

Caregiver Training Benefit – Caregiver Training Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in the Insured's Home. Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return to Home where the Insured can be cared for by the person receiving the training. Benefits are payable for the Covered Expenses the Insured incurs for Caregiver Training up to the Caregiver Training Benefit Lifetime Maximum.

Nonforfeiture Benefit of the EBR – Upon lapse of the EBR, the Owner is eligible for a Nonforfeiture Benefit of either the Return of Premium Benefit, as described above under Section 6, or a limited amount of paid-up long-term care benefits, as described in the EBR.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for benefits under the coverage, we must verify that the Insured is a Chronically Ill Individual, as certified by a Licensed Health Care Practitioner within the past 12 months. In addition:

- The cost incurred is a Covered Expense under the coverage and the service for such Covered Expense is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under the Riders must be in force on the dates the care is received;
- The Insured must not have exhausted the applicable limits on the specific benefits claimed, or the Maximum Benefit Limit;
- The Insured must meet the additional requirements for the specific benefits claimed; and
- The Insured must satisfy the applicable Elimination Period.

Long-Term Care Benefits	**Elimination Period**
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[90] Days
Care Coordination Benefit	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[90] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[90] Days

10. EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions – We will not reduce or deny any claim under the Riders because of a sickness or physical or medical condition disclosed on the application.

Non-eligible Facilities and Providers – Any facility or provider for a given benefit that does not fall within the "Definitions" section, starting on page 8, would be a non-eligible facility or provider for that benefit.

Non-eligible Levels of Care – Coverage does not include any services that do not constitute Qualified Long-Term Care Services. Care from family members is covered only where specifically indicated below in Exclusions/Exceptions and Limitations.

Exclusions/Exceptions and Limitations – We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while the Riders are not in force, except as provided in the provision.

Duration – The ABR provides two years of long-term care benefits. The EBR provides between one and six years of additional long-term term care benefits, depending on the duration elected. These durations may increase or decrease depending on how the Policy and Rider benefits are used.

THIS COVERAGE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, consider whether and how the benefits of this coverage may be adjusted. One of the available Inflation Benefit Options may be elected at the time of purchase to increase the coverage. While the Insured will be underwritten in order to purchase the coverage, once the Inflation Benefit Option is in effect, no further underwriting is required. There is a premium charge for including any Inflation Benefit Option in the coverage. The premium charge varies depending on which Inflation Benefit Option is elected.

Unless rejected, one of the following will apply to the Riders:

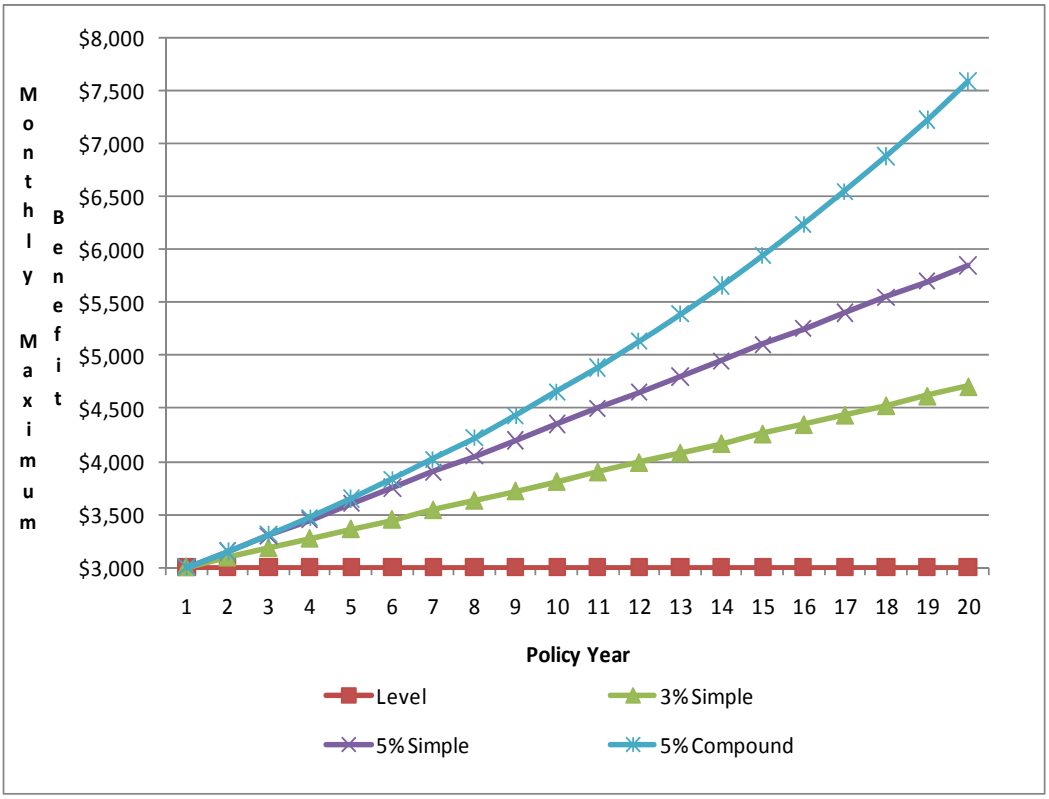
- 5% Compound Inflation Benefit Option
- 5% Simple Inflation Benefit Option
- 3% Simple Inflation Benefit Option

Simple Inflation Benefit Option (3% or 5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to the selected percentage of the initial Monthly Maximum Benefit Amount. The Maximum Benefit Limits will be increased by the same proportion as the Monthly Maximum Benefit Amount.

Compound Inflation Benefit Option (5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to 5% of the Monthly Maximum Benefit Amount in effect immediately prior to the increase. The Maximum Benefit Limits will also be increased on each Policy anniversary by an amount equal to 5% of the Maximum Benefit Limits in effect immediately prior to the increase.

INFLATION PROTECTION – GRAPHIC COMPARISONS

The following chart compares and contrasts benefit levels for coverage with no inflation protection and coverage with the 3% simple, 5% simple and 5% compound Inflation Benefit Options offered with the coverage. The chart assumes an initial Monthly Maximum Benefit Amount of $3,000.



The following chart shows a relative cost comparison of total premiums with and without an Inflation Benefit Option. At each issue age and gender combination, the chart shows the total premium with the Inflation Benefit Option divided by the total premium without the Inflation Benefit Option. For example, total premiums for a 35 year old female for coverage with the 5% simple Inflation Benefit Option will cost 163% of the total premiums for coverage with no Inflation Benefit Option. The chart assumes a 2 year ABR and 2 year EBR were elected.

Issue Age	Gender	Inflation Option for 4 Year LTC Benefit			
		None	3% Simple	5% Simple	5% Compound
35	Male	100%	117%	130%	215%
	Female	100%	131%	163%	376%
45	Male	100%	121%	140%	192%
	Female	100%	132%	163%	315%
55	Male	100%	124%	150%	173%
	Female	100%	131%	163%	257%
65	Male	100%	124%	148%	162%
	Female	100%	131%	157%	245%
75	Male	100%	121%	138%	160%
	Female	100%	145%	170%	240%

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once an Insured's application is approved, coverage is provided for an Insured who is a Chronically Ill Individual as a result of Alzheimer's disease or any related degenerative and dementing illnesses.

13. PREMIUM

The single premium for the coverage will be determined based on the amount of coverage, the Inflation Benefit Option elected, if any, and the Insured's issue age and gender as described in the application and illustrated in the chart in section 11.

14. ADDITIONAL FEATURES

Underwriting – We will underwrite the Insured's application by reviewing one or more of the following: the information submitted on the application; an attending Physician's report; copies of the Insured's medical records; a medical evaluation; a telephone interview; and an in-person interview.

Added Protection Against Lapse – If the Insured's coverage terminates due to lapse, we will provide a retroactive continuation of coverage if within five (5) months of the termination date the Insured provides us with proof the Insured was a Chronically Ill Individual, beginning on or before the termination date. All past due premiums, outstanding Policy Debt prior to the date of lapse and any amount refunded due to lapse in connection with the Rider Return of Premium Benefit must be paid. In that event, the Policy and Riders will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE COVERAGE.

DEFINITIONS

In this section, we define certain terms used throughout this Outline of coverage. Defined terms are usually capitalized to show emphasis.

ABR – means the Accelerated Benefit Rider.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing ongoing Assisted Living Care and related services. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;

- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under the ABR or EBR. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

EBR – means the Extended Benefit Rider.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or experience to provide such care. If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:

- Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;

- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and
- Provide ongoing supervision and training to its employees appropriate to the services to be provided.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit Limit – is the total amount of lifetime benefits payable under the ABR or EBR, as applicable, as described in the ABR or EBR.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum Benefit Amount – is the total amount of monthly benefits payable under the ABR or EBR, as applicable.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services.

Policy – means the flexible premium adjustable life insurance policy Form ICC11 P11PPC to which the Riders are attached.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Riders – means the ABR and the EBR.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

Terminal Illness Benefit Payment – means the actual dollar amount of benefit received under the Terminal Illness Benefit of the Policy.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
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(800) 347-7787 • Fax (866) 964-4860
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APPLICATION FOR [PACIFIC PREMIERCARE]

For Individual Life Insurance with Long-Term (LTC) Benefits.

PROPOSED INSURED

1A. Name: First | MI | Last

B. Gender ☐ Male ☐ Female

C. Residence Address: Street | City | State | Zip Code

D. Date of Birth | E. Place of Birth (State/Country) | F. Soc. Sec. # | G. Telephone # (include area code)

2A. Employer's Name | B. Occupation

3A. Proposed Insured is a: ☐ U.S. Citizen ☐ U.S. Permanent Resident ☐ Foreign National

B. If Foreign National, provide Country | C. Visa Type | 4A. Gross Annual Income $ | B. Net Worth $

5. Is the Proposed Insured married or in a legally recognized civil union or domestic partnership? ☐ Yes ☐ No

POLICY INFORMATION

1. Face Amount $ | 2. Single Premium $ | 3. Amount submitted with Temporary Insurance Agreement (TIA) $

4. Long-Term Care (LTC) Benefit Duration: (Includes 2 year Accelerated Benefit Rider plus 0-6 years of Extended Benefit Rider.)
☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years ☐ 7 Years ☐ 8 Years

5. Inflation Benefit Option (select one)
☐ 3% Simple ☐ 5% Simple ☐ 5% Compound ☐ Reject All Inflation Benefit Options

PRIMARY POLICYOWNER (Complete if other than Proposed Insured.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all trustees to sign? ☐ Yes ☐ No (If No, indicate in Remarks who is required to sign.)

ADDITIONAL POLICYOWNER (If more than one individual is named as policyowner, they will own policy as joint tenants with rights of survivorship unless otherwise stated.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all Trustees to sign? ☐ Yes ☐ No (If No, indicate who is required to sign in Remarks.)

Payor Of Premium

1. Payor of premium is (Check one): ☐ Proposed Insured ☐ Primary Policyowner ☐ Additional Primary Policyowner ☐ Other

2A. If "Other" indicate Name of Payor

B. Address: Street City State Zip Code

Protection Against Unintended Lapse

I, the Policyowner, understand that I have the right to designate at least one person other than myself to receive notices of lapse or termination of this policy, which contains long-term care benefits. I also understand that I have the opportunity to change this written designation at any time. My selection is as follows:

1A. ☐ I elect NOT to designate another person to receive notice of lapse or termination.

B. ☐ I designate the person listed below to receive copies of any notice of lapse or termination.

C. Name

D. Address: Street City State Zip Code

Primary Beneficiary (If percentages are left blank, all named Primary Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Contingent Beneficiary (If percentages are left blank, all named Contingent Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Certification Of Policyowner's Taxpayer Identification Number

Under penalties of perjury, I, the Policyowner, certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen or other U.S. person (defined in the instructions in item 3 of the Certification on the official IRS Form W-9).**

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Tax Reporting On Distributions To Foreign Nationals

While Pacific Life Insurance Company (PLIC) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, PLIC does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, PLIC's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. PLIC does not provide tax or legal advice, and nothing contained herein should be construed as such.

Remarks

Existing Insurance And Replacement Information For Proposed Insured

	YES	NO
1. Do you have any existing life insurance or annuity contracts, including those with long-term care (LTC) coverage?	☐	☐
2A. Do you have another long-term care insurance policy or certificate (including a health care service contract or health maintenance organization contract), whether existing or pending? (If Yes, provide details in the chart below.)	☐	☐
B. Did you have another long-term care insurance policy or certificate in force during the last 12 months that has terminated? (If Yes, provide details in the chart below.)	☐	☐

Company	Coverage Type		Policy Status			Termination Date
	LTC	Health	Existing	Pending	Terminated	

	YES	NO
3. Are you covered by Medicaid?	☐	☐
4. Have you ever applied for life insurance, long-term care, health or disability insurance and been declined, postponed or offered on a basis other than as applied-for? (If Yes, provide details in Remarks.)	☐	☐
5A. Do you intend to stop premium payments, replace, surrender, forfeit, assign to the insurer, or take a cash withdrawal or loan from any life insurance policy or annuity contract to pay premiums on the applied-for policy? (If Yes, provide details in the chart below.)	☐	☐
B. Do you intend to replace any of your medical or health insurance coverage, including any of your long-term care coverage, with this applied-for policy? (If Yes, provide details in the chart below.)	☐	☐

Policy #	Coverage Type						Company	Amount	1035 Exchange
	Life	Life+ LTC	Annuity	Annuity + LTC	LTC	Health			

General Information (Provide details in Remarks)

	YES	NO
1. Are you working at least 24 hours per week outside the home?	☐	☐
2. Have you missed more than one consecutive week of work due to illness or injury in the past 24 months?	☐	☐
3. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember?	☐	☐
4. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing?	☐	☐
5. Do you have regular exercise routines or hobbies that require physical activity?	☐	☐
6. Do you intend to travel or reside outside the United States within the next 2 years?	☐	☐
7. Have you been convicted of a felony within the past 5 years?	☐	☐
8. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?	☐	☐

Proposed Insured's Physician Information

1A. Provide full name, address, and phone number of ☐ Primary Physician ☐ Specialty Physician

B. Physician Name | C. Telephone # (include area code)

D. Address: Street | City | State | Zip Code

2. Date and reason of last visit:_____

3. Tests performed & treatment received:_____

Remarks

MEDICAL INFORMATION (Provide details to any Yes answers in Remarks. If more space is needed, use an additional sheet.)

	Yes	No
1. Have any of your immediate family members (parents, brothers or sisters) prior to age 60 been diagnosed with polycystic kidney disease or Huntington's chorea?	☐	☐
2. Currently, or within the past 5 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance, or any other form of disability insurance?	☐	☐
3. Height:_____ Weight:_____ Has your weight changed 10 pounds or more in the past 2 years?	☐	☐
4. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
5. Currently, or within the last 5 years, have you had or do you need or receive assistance with any of the following: laundry, cleaning, shopping, use of transportation, telephone use, meal preparation, managing your finances or managing your medication?	☐	☐
6. Currently, or within the last 5 years, have you had or do you use a wheelchair, walker, cane, quad cane, scooter, oxygen, catheter, dialysis machine, or other mechanical device?	☐	☐
7. Within the last 5 years have you been confined or been given medical advice by a member of the medical profession to be admitted to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility or attended adult day care?	☐	☐
8. Are you currently living in an Assisted Living facility or Independent Community?	☐	☐
9. Within the last 5 years, have you had or been given medical advice by a member of the medical profession to have a check-up, EKG, x-ray, CT scan, blood, or urine test, or any other diagnostic test, except for a test for the Human Immune Deficiency Virus (HIV) infection?	☐	☐
10. Within the last 5 years, have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been given medical advice by a member of the medical profession to have any hospitalization or surgery which has not been scheduled or completed?	☐	☐
11. Except for HIV, have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession and/or taken medication for:		
a. Alzheimer's disease, dementia, forgetfulness, memory loss, or any other cognitive impairment?	☐	☐
b. Chest pain, angina, congestive heart failure, heart disease, heart murmur, coronary artery disease, peripheral vascular disease, atrial fibrillation, high blood pressure, or other disorders of the heart or blood vessels?	☐	☐
c. Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Muscular Dystrophy, Huntington's chorea, or Systemic Lupus?	☐	☐
d. Ulcers, colitis, jaundice, cirrhosis, chronic hepatitis, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney, or urinary bladder?	☐	☐
e. Transient ischemic attack, stroke or paralysis?	☐	☐
f. Syncope, vertigo, loss of balance, tremor or falls, seizures, fainting, dizziness, or epilepsy?	☐	☐
g. Chronic fatigue, fibromyalgia, or polymyalgia rheumatica?	☐	☐
h. Cancer, leukemia, lymphoma, malignant melanoma, or tumors or cysts of any kind, whether malignant or benign?	☐	☐
i. Arthritis, Rheumatoid Arthritis, gout, Osteoporosis, or any disorder of the back, spine, muscles, nerves, bones, or joints?	☐	☐
j. Diabetes, thyroid, or other endocrine or glandular disorder?	☐	☐
k. Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells, or bone marrow, or any lymph node disorder?	☐	☐
l. Asthma, emphysema, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD), allergies, sleep apnea, or any other disorder of the respiratory system?	☐	☐
m. Any disorder of the eyes, ears, nose, or throat?	☐	☐
n. Any disorder of the testicles, prostate, breasts, ovaries, uterus, or cervix?	☐	☐
12. Within the last 5 years, have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession and/or taken medication for anxiety, depression or any psychiatric or mental health disorder?	☐	☐
13. What, if any, other medications do you take regularly? (Provide details in Remarks.)		
14. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquire Immune Deficiency Syndrome (AIDS)?	☐	☐
15. Have you used tobacco products (cigarettes, cigars, pipe) during the past 48 months? If "yes", provide amount used and frequency. _____ If quit, when was tobacco last used?_____	☐	☐
16. Do you use alcoholic beverages? If Yes, provide type, frequency & amount:	☐	☐
17. Have you ever received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
18. Within the last 5 years have you:		
a. Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens?	☐	☐
b. Used any tranquilizers, sedatives or narcotic drugs or any prescription drug outside a physician's instructions?	☐	☐

REMARKS

Declarations

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

1. Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by PLIC as indicated under the title Endorsement, where permitted. All other changes made to the application or policy by PLIC will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears in the Producer Certification section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
3. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire single premium is paid only if at that time the Proposed Insured is alive.
4. If I have given money and received a TIA, I understand that if the Proposed Insured dies before a policy is delivered; the death benefit will be limited to the TIA coverage limit.
5. PLIC may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a Department of Motor Vehicle report or other questionnaire, test or a prescription drug or medication report.
6. No Producer is authorized to make or change contracts or insurance policies on the behalf of PLIC and no Producer may alter the terms of this application, the TIA, or the policy, nor does the Producer have the authority to waive any of PLIC's rights or requirements.
7. The Producer will receive compensation in connection with the sale of this policy.
8. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Producer or PLIC about the specific premium and risk class referenced in my policy.
9. I represent that all parties have an insurable interest in the life of the Proposed Insured.
10. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
11. The Proposed Insured received the Disclosure Notice and Privacy Notice — Health (HIPAA).
12. I HAVE READ the completed Application and all related forms for [Pacific PremierCare] before signing below. All statements and answers on this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief.
13. For purposes of this application, the proposed insured is considered the applicant, unless a policyowner is also indicated. In such case, the policyowner is considered the applicant.
14. This application will be attached to and made part of the policy.

Inflation Benefit Option

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection.

☐ I hereby **REJECT** the 5% compound Inflation Benefit Option and apply for the Inflation Benefit Option as shown in the Policy Information section, on page 1, question 5.

☐ I hereby **REJECT** all Inflation Benefit Options, including the 5% compound Inflation Benefit Option.

New Business Date Stamp (For Internal Use Only)

Modified Endowment Contract (MEC) Status

The policy is expected to be or become a MEC: ☐ Yes (Policyowner must initial below) ☐ No

Regarding Distributions:

- Distributions from the policy, including those taken during the two years prior to the policy becoming a MEC, can result in earlier income taxation.
- Distributions include (but may not be limited to) pre-death disbursements such as withdrawals, policy loans (including interest not paid when due), surrenders, and cash dividends, and also transfers of ownership and assignment of policy values.
- The taxable portion of any Distribution taken before age 59 ½ may be subject to a 10% penalty by the IRS. This 10% penalty always applies if the MEC owner is not treated as a natural person for tax purposes; e.g. is a corporation or trust.
- For purposes of determining the taxable portion of Distributions, federal tax law provides that all MECs issued by the same insurance company to the same Policyowner during any calendar year shall be treated as one MEC.
- PLIC will report income relating to such Distributions to the IRS as required by federal law and regulations.

Additional Information:

- Once a policy becomes a MEC that status cannot change. Any policy received in exchange for a MEC policy will also be considered a MEC.
- For specific questions regarding the taxation of your MEC policy, please consult your tax advisor.

INITIAL HERE ☐ **By initialing here, the Policyowner confirms their understanding that the policy to be issued is now or will become a MEC at or after issue, and accepts MEC status for the policy.**

Signatures

INITIAL HERE ☐ By initialing here, the Policyowner confirms they received the Outline of Coverage, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Life Insurance Buyer's Guide, and A Shoppers Guide to Long-Term Care Insurance.

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

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

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust) have been met.

You represent that you have read and reviewed the answers in this application and confirm they are true as of the below date that this application is signed.

CAUTION: If your answers on this application are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

SIGNED IN:

City	State

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE **X**

Proposed Insured's Signature

SIGN HERE **X**

Policyowner's Signature, if other than Proposed Insured, and include **Title,** if Corporation, Trust, or Business Entity.

SIGN HERE **X**

Additional Policyowner's Signature & Title, if applicable

Producer's Certification

	Yes	No
1. Does the Insured have any existing life insurance or annuities, including those with LTC coverage?	☐	☐
2. Do you know or have any reason to believe that a replacement of insurance is involved?	☐	☐
3. I have discussed the appropriateness of replacement, followed applicable state laws, PLIC's written guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If No, explain on an additional sheet.)	☐	☐
4. Based upon my review of, among other things, the Policyowner's and Proposed Insured's age, income, net worth, tax and family status, and current plan of insurance, I certify that the purchase of this policy meets the Policyowner's insurance needs and financial objectives, and is consistent with PLIC's suitability standards. I have documented and will retain my suitability analysis and conclusions.	☐	☐

5. List below any other Health Insurance you have sold to the Proposed Insured that is currently in force, or purchased within the last 5 years and no longer in force. (If No, explain on an additional sheet.)

Company	Policy Number	Year of Issue	Policy Status
			☐ In force ☐ No longer in force
			☐ In force ☐ No longer in force

I have reviewed the application and all related forms with the Insured and Policyowner(s).

SIGN HERE **X**

Soliciting Producer's Signature

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

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

STATEMENT OF GOOD HEALTH AND INSURABILITY

Proposed Insured's Name: First MI Last	Policy Number

If your answer to any of the following questions is "Yes", provide full details and dates in Remarks (or attach sheets, if necessary).

Since the date of the [Pacific PremierCare] telephone interview:

	YES	NO
1. Has there been any change in your health?	☐	☐
2. Have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
3. Have there been any changes to any of the medical information questions on the application?	☐	☐
4. Have you been declined, rated, or postponed for long-term care insurance?	☐	☐

Caution: If your answers on the application or Statement of Good Health and Insurability are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

REMARKS

SIGNATURES

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

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE
X
Proposed Insured's Signature

SIGN HERE
X
Policyowner's Signature

SIGN HERE
X
Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

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[PACIFIC PREMIERCARE] TEMPORARY INSURANCE AGREEMENT (TIA)

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

This TIA provides a limited amount of life insurance coverage, for a limited period of time, subject to the Terms and Conditions shown below.

Payment in the amount of $ _____(checks must be made payable to "Pacific Life Insurance Company") is made in connection with this TIA on the life of the proposed insured named above.

Within the past 90 days, have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been given medical advice by a member of the medical profession to have any hospitalization or surgery which has not been scheduled or completed? ☐ Yes ☐ No

If the above question is answered YES or LEFT BLANK, no representative of Pacific Life Insurance Company (PLIC) is authorized to accept money, and NO COVERAGE will take effect under this TIA.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $600,000 MAXIMUM	If money has been accepted by PLIC as payment in connection with this TIA and if the Proposed Insured dies while this TIA is in effect, PLIC will pay the designated beneficiary the amount of death benefits, if any, that would be payable under a requested [Pacific PremierCare] Policy if such were issued as shown which amount shall not exceed $600,000.
DATE COVERAGE BEGINS	Temporary life insurance under this TIA will begin on the date of this TIA, but only if a request for a [Pacific PremierCare] Policy has been initiated, and payment is received by PLIC on the same date or not more than 10 days prior to the date of this TIA.
DATE COVERAGE TERMINATES (45 DAY MAXIMUM)	Temporary life insurance under this TIA will terminate automatically on the earliest of: a. 30 days from date of this TIA if a required phone history interview is not completed and received by PLIC; or b. 45 days from the date of this TIA; or c. the date any [Pacific PremierCare] Policy is offered; or d. five days after the date PLIC mails notice of termination of coverage under this TIA and refunds the full amount of payment referenced above.
LIMITATIONS	• This TIA does not provide benefits for long term care coverage. • Fraud or material misrepresentation made in a request for a [Pacific PremierCare] Policy or any Application or in the answer to the above question in this TIA invalidates this TIA, and PLIC's liability shall be no greater than the refund of any premium payment made in connection with this TIA. • If the Proposed Insured dies by suicide, PLIC's liability under this TIA is limited to a refund of the payment made. • There is no coverage under this TIA if the check submitted as payment is not honored by the bank on first presentation. • If the Proposed Insured has more than one TIA in effect, the maximum aggregate coverage under any and all TIAs is $1,000,000. • **No one is authorized to waive or modify any of the provisions of this TIA.**

I HAVE RECEIVED A COPY OF AND HAVE READ THIS TIA AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL OF ITS TERMS AND CONDITIONS.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE
X
Proposed Insured's Signature

SIGN HERE
X
Policyowner's Signature, if other than Proposed Insured include Title, if Corporation, Trust or Business Entity

SIGN HERE
X
Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

PACIFIC LIFE INSURANCE COMPANY
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(800) 347-7787 • Fax (866) 964-4860
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PACIFIC LIFE

FOREIGN RESIDENCE AND TRAVEL QUESTIONNAIRE – FUTURE

PROPOSED INSURED

Name: First	MI	Last	Date of Birth (mm/dd/yyyy)

FOREIGN RESIDENCE (Complete this section if your primary residence is outside of the United States, Canada, Guam, or Puerto Rico.)

Primary Residence: City	Country	How Long? yr mo
Secondary Residence: City	Country	How Long? yr mo

If you expect to do any additional traveling while residing abroad complete the Future Travel section below.

Future Travel (Complete this section for all intended travel outside the United States (or your country of residence) for the **next** 2 years. Use a separate sheet if necessary.)

	Trip 1	Trip 2	Trip 3
Country Name			
City(ies) or Region Expected to Visit			
Number of Trips			
Length of Stay	____ Days ____ Weeks ____ Months	____ Days ____ Weeks ____ Months	____ Days ____ Weeks ____ Months
Expected Dates	From / To	From / To	From / To
Accommodations:	☐ Hotel ☐ Staying with family ☐ Other _____	☐ Hotel ☐ Staying with family ☐ Other _____	☐ Hotel ☐ Staying with family ☐ Other _____
Purpose of Trip:	☐ Personal ☐ Business ☐ Missionary Details:	☐ Personal ☐ Business ☐ Missionary Details:	☐ Personal ☐ Business ☐ Missionary Details:

SIGNATURES

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

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE

X

Proposed Insured's Signature

SIGN HERE

X

Producer's Signature

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

READABILITY CERTIFICATION AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

This is the same application that is included in the Form Schedule.

Attachment:

A11PPC.pdf

Item Status: **Status Date:**

Satisfied - Item: Health - Actuarial Justification

Comments:

Attachments:

PAC Life Act Memo Life 2011 10 26.pdf

PACLife_ActMemo RS 2011 10 26.pdf

Item Status: **Status Date:**

Satisfied - Item: Outline of Coverage

Comments:

This is the same outline of coverage that is included in the Form Schedule.

Attachment:

N11OOC.pdf

Item Status: **Status**

Date:

Satisfied - Item: Supporting Documentation

Comments:

The following documents are submitted as informational:

Authorization to Obtain Information
Authorization to Release Information
Disclosure Notice - How We Use Your Information
Privacy Notice for Personal Health Information
Things You Should Know Before You Buy LTC
Long Term Care Insurance Suitability
Long Term Care Personal Worksheet
Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance
Pacific PremierCare Ticket
Life Replacement Notice

Attachments:

A11AUT.pdf
A11DIS.pdf
LTCLT.pdf
M11SLT.pdf
N11TYK.pdf
N11PHI.pdf
M11RPL.pdf
A11ARI.pdf
M11SPW.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachments:

Statement of VariabilityA11PPC - Generic.pdf
Statement of VariabilityA11SOH - Generic.pdf
Statement of VariabilityA11TIA - Generic.pdf
Statement of VariabilityE11LRD - Generic.pdf
Statement of VariabilityR11ABR - Generic.pdf
Statement of VariabilityR11EBR - Generic.pdf

Statement of VariabilityR11AVT - Generic.pdf
Statement of VariabilityN11OOC.pdf
Statement of VariabilityP11PPC - Generic.pdf

Item Status: **Status Date:**

Satisfied - Item: Comparison Documents
Comments:
Attachments:
P11PPC AR (Compare).pdf
A11SOHS-redline version.pdf
A11TIAS-redlined version.pdf
M11SPW-redlilned version.pdf
R11AVTCompare.pdf
N11OOC Compare10.26.2011.pdf
R11EBRCompare10.26.2011.pdf
R11ABR _Compare_.pdf
A11PPC-redlined version with Compact Objections.pdf

Item Status: **Status Date:**

Satisfied - Item: Complaint & Guaranty Association Notices
Comments:
Attachments:
AR1.pdf
ST81.pdf

Item Status: **Status Date:**

Satisfied - Item: Certificatons
Comments:
Attachments:
Arkansas Certification - P11PPC.pdf
Arkansas Reg 34 Certificate of Compliance.pdf

READABILITY CERTIFICATION

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

Policy Form Numbers & Flesch Scores:		
	P11PPC	50.1
	R11ABR	50.0
	R11EBR	50.0
	R11LRD	70.6
	R11AVT	50.1
	A11PPC	50.2
	A11SOH	50.6
	A11TIA	50.1
	A11TFU	52.9

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

Test type: 10 point

I certify that in my judgment this filing is:

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

I believe this filing:

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

Signed for the Company at Aliso Viejo, California on 10/25/2011

SIGNATURE

THOMAS S. BEADLESTON
NAME

VICE PRESIDENT
TITLE

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

APPLICATION FOR [PACIFIC PREMIERCARE]

For Individual Life Insurance with Long-Term (LTC) Benefits.

PROPOSED INSURED

1A. Name: First | MI | Last

B. Gender ☐ Male ☐ Female

C. Residence Address: Street | City | State | Zip Code

D. Date of Birth | E. Place of Birth (State/Country) | F. Soc. Sec. # | G. Telephone # (include area code)

2A. Employer's Name | B. Occupation

3A. Proposed Insured is a: ☐ U.S. Citizen ☐ U.S. Permanent Resident ☐ Foreign National

B. If Foreign National, provide Country | C. Visa Type | 4A. Gross Annual Income $ | B. Net Worth $

5. Is the Proposed Insured married or in a legally recognized civil union or domestic partnership? ☐ Yes ☐ No

POLICY INFORMATION

1. Face Amount $ | 2. Single Premium $ | 3. Amount submitted with Temporary Insurance Agreement (TIA) $

4. Long-Term Care (LTC) Benefit Duration: (Includes 2 year Accelerated Benefit Rider plus 0-6 years of Extended Benefit Rider.)
☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years ☐ 7 Years ☐ 8 Years

5. Inflation Benefit Option (select one)
☐ 3% Simple ☐ 5% Simple ☐ 5% Compound ☐ Reject All Inflation Benefit Options

PRIMARY POLICYOWNER (Complete if other than Proposed Insured.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all trustees to sign? ☐ Yes ☐ No (If No, indicate in Remarks who is required to sign.)

ADDITIONAL POLICYOWNER (If more than one individual is named as policyowner, they will own policy as joint tenants with rights of survivorship unless otherwise stated.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all Trustees to sign? ☐ Yes ☐ No (If No, indicate who is required to sign in Remarks.)

Payor Of Premium

1. Payor of premium is (Check one): ☐ Proposed Insured ☐ Primary Policyowner ☐ Additional Primary Policyowner ☐ Other

2A. If "Other" indicate Name of Payor

B. Address: Street City State Zip Code

Protection Against Unintended Lapse

I, the Policyowner, understand that I have the right to designate at least one person other than myself to receive notices of lapse or termination of this policy, which contains long-term care benefits. I also understand that I have the opportunity to change this written designation at any time. My selection is as follows:

1A. ☐ I elect NOT to designate another person to receive notice of lapse or termination.

B. ☐ I designate the person listed below to receive copies of any notice of lapse or termination.

C. Name

D. Address: Street City State Zip Code

Primary Beneficiary (If percentages are left blank, all named Primary Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Contingent Beneficiary (If percentages are left blank, all named Contingent Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Certification Of Policyowner's Taxpayer Identification Number

Under penalties of perjury, I, the Policyowner, certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen or other U.S. person (defined in the instructions in item 3 of the Certification on the official IRS Form W-9).**

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Tax Reporting On Distributions To Foreign Nationals

While Pacific Life Insurance Company (PLIC) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, PLIC does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, PLIC's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. PLIC does not provide tax or legal advice, and nothing contained herein should be construed as such.

Remarks

Existing Insurance And Replacement Information For Proposed Insured

	YES	NO
1. Do you have any existing life insurance or annuity contracts, including those with long-term care (LTC) coverage?	☐	☐
2A. Do you have another long-term care insurance policy or certificate (including a health care service contract or health maintenance organization contract), whether existing or pending? (If Yes, provide details in the chart below.)	☐	☐
B. Did you have another long-term care insurance policy or certificate in force during the last 12 months that has terminated? (If Yes, provide details in the chart below.)	☐	☐

Company	Coverage Type		Policy Status			Termination Date
	LTC	Health	Existing	Pending	Terminated	

	YES	NO
3. Are you covered by Medicaid?	☐	☐
4. Have you ever applied for life insurance, long-term care, health or disability insurance and been declined, postponed or offered on a basis other than as applied-for? (If Yes, provide details in Remarks.)	☐	☐
5A. Do you intend to stop premium payments, replace, surrender, forfeit, assign to the insurer, or take a cash withdrawal or loan from any life insurance policy or annuity contract to pay premiums on the applied-for policy? (If Yes, provide details in the chart below.)	☐	☐
B. Do you intend to replace any of your medical or health insurance coverage, including any of your long-term care coverage, with this applied-for policy? (If Yes, provide details in the chart below.)	☐	☐

Policy #	Coverage Type						Company	Amount	1035 Exchange
	Life	Life+ LTC	Annuity	Annuity + LTC	LTC	Health			

General Information (Provide details in Remarks)

	YES	NO
1. Are you working at least 24 hours per week outside the home?	☐	☐
2. Have you missed more than one consecutive week of work due to illness or injury in the past 24 months?	☐	☐
3. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember?	☐	☐
4. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing?	☐	☐
5. Do you have regular exercise routines or hobbies that require physical activity?	☐	☐
6. Do you intend to travel or reside outside the United States within the next 2 years?	☐	☐
7. Have you been convicted of a felony within the past 5 years?	☐	☐
8. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?	☐	☐

Proposed Insured's Physician Information

1A. Provide full name, address, and phone number of ☐ Primary Physician ☐ Specialty Physician

B. Physician Name | C. Telephone # (include area code)

D. Address: Street | City | State | Zip Code

2. Date and reason of last visit:_____

3. Tests performed & treatment received:_____

Remarks

MEDICAL INFORMATION (Provide details to any Yes answers in Remarks. If more space is needed, use an additional sheet.)

	Yes	No
1. Have any of your immediate family members (parents, brothers or sisters) prior to age 60 been diagnosed with polycystic kidney disease or Huntington's chorea?	☐	☐
2. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance, or any other form of disability insurance?	☐	☐
3. Height:_____ Weight:_____ Has your weight changed 10 pounds or more in the past 2 years?	☐	☐
4. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
5. Currently, or within the last 5 years, have you had or do you need or receive assistance with any of the following: laundry, cleaning, shopping, use of transportation, telephone use, meal preparation, managing your finances or managing your medication?	☐	☐
6. Currently, or within the last 5 years, have you had or do you use a wheelchair, walker, cane, quad cane, scooter, oxygen, catheter, dialysis machine, or other mechanical device?	☐	☐
7. Within the last 5 years have you been confined or recommended admission to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility or attended adult day care?	☐	☐
8. Are you currently living in an Assisted Living facility or Independent Community?	☐	☐
9. Within the last 5 years, have you had or been advised to have a check-up, EKG, x-ray, CT scan, blood, or urine test, or any other diagnostic test, except for a test for the Human Immune Deficiency Virus (HIV) infection?	☐	☐
10. Within the last 5 years, have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been advised or recommended to have any hospitalization or surgery which has not been scheduled or completed?	☐	☐
11. Except for HIV, have you ever been told you have, been diagnosed with or been treated by a physician and/or taken medication for:		
a. Alzheimer's disease, dementia, forgetfulness, memory loss, or any other cognitive impairment?	☐	☐
b. Chest pain, angina, congestive heart failure, heart disease, heart murmur, coronary artery disease, peripheral vascular disease, atrial fibrillation, high blood pressure, or other disorders of the heart or blood vessels?	☐	☐
c. Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Muscular Dystrophy, Huntington's chorea, or Systemic Lupus?	☐	☐
d. Ulcers, colitis, jaundice, cirrhosis, chronic hepatitis, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney, or urinary bladder?	☐	☐
e. Transient ischemic attack, stroke or paralysis?	☐	☐
f. Syncope, vertigo, loss of balance, tremor or falls, seizures, fainting, dizziness, or epilepsy?	☐	☐
g. Chronic fatigue, fibromyalgia, or polymyalgia rheumatica?	☐	☐
h. Any nervous or mental disorder or received counseling for anxiety, depression, schizophrenia, stress, or any other emotional condition?	☐	☐
i. Cancer, leukemia, lymphoma, malignant melanoma, or tumors or cysts of any kind, whether malignant or benign?	☐	☐
j. Arthritis, Rheumatoid Arthritis, gout, Osteoporosis, or any disorder of the back, spine, muscles, nerves, bones, or joints?	☐	☐
k. Diabetes, thyroid, or other endocrine or glandular disorder?	☐	☐
l. Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells, or bone marrow, or any lymph node disorder?	☐	☐
m. Asthma, emphysema, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD), allergies, sleep apnea, or any other disorder of the respiratory system?	☐	☐
n. Any disorder of the eyes, ears, nose, or throat?	☐	☐
o. Any disorder of the testicles, prostate, breasts, ovaries, uterus, or cervix?	☐	☐
p. Any mental or physical disorder not listed above?	☐	☐
12. What, if any, other medications do you take regularly? (Provide details in Remarks.)		
13. Have you ever tested positive for exposure to HIV infection or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
14. Have you used tobacco products (cigarettes, cigars, pipe) during the past 48 months? If "yes", provide amount used and frequency. _____If quit, when was tobacco last used?_____	☐	☐
15. Do you use alcoholic beverages? If Yes, provide type, frequency & amount:	☐	☐
16. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medications, prescribed or not?	☐	☐
17. Within the last 10 years have you:		
a. Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens?	☐	☐
b. Used any tranquilizers, sedatives or narcotic drugs or any prescription drug outside a physician's instructions?	☐	☐

REMARKS

Declarations

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

1. Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by PLIC as indicated under the title Endorsement, where permitted. All other changes made to the application or policy by PLIC will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears in the Producer Certification section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
3. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire single premium is paid only if at that time the Proposed Insured is alive, and all answers in this application and on the Statement of Good Health & Insurability that are material to the risk are still true and complete.
4. If I have given money and received a TIA, I understand that if the Proposed Insured dies before a policy is delivered; the death benefit will be limited to the TIA coverage limit.
5. PLIC may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a Department of Motor Vehicle report or other questionnaire, test or a prescription drug or medication report.
6. I must inform the Producer or PLIC in writing of any changes in the health of the Proposed Insured or if any of the statements or answers on this application change prior to delivery of the policy.
7. My statements and answers in this application must continue to be true as of the date I receive the policy.
8. No Producer is authorized to make or change contracts or insurance policies on the behalf of PLIC and no Producer may alter the terms of this application, the TIA, or the policy, nor does the Producer have the authority to waive any of PLIC's rights or requirements.
9. The Producer will receive compensation in connection with the sale of this policy.
10. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Producer or PLIC about the specific premium and risk class referenced in my policy.
11. I represent that all parties have an insurable interest in the life of the Proposed Insured.
12. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
13. The Proposed Insured received the Disclosure Notice and Privacy Notice — Health (HIPAA).
14. I HAVE READ the completed Application and all related forms for [Pacific PremierCare] before signing below. All statements and answers on this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief.
15. For purposes of this application, the proposed insured is considered the applicant, unless a policyowner is also indicated. In such case, the policyowner is considered the applicant.
16. This application will be attached to and made part of the policy.

Inflation Benefit Option

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection.

☐ I hereby **REJECT** the 5% compound Inflation Benefit Option and apply for the Inflation Benefit Option as shown in the Policy Information section, on page 1, question 5.

☐ I hereby **REJECT** all Inflation Benefit Options, including the 5% compound Inflation Benefit Option.

New Business Date Stamp (For Internal Use Only)

Modified Endowment Contract (MEC) Status

The policy is expected to be or become a MEC: ☐ Yes (Policyowner must initial below) ☐ No

Regarding Distributions:

- Distributions from the policy, including those taken during the two years prior to the policy becoming a MEC, can result in earlier income taxation.
- Distributions include (but may not be limited to) pre-death disbursements such as withdrawals, policy loans (including interest not paid when due), surrenders, and cash dividends, and also transfers of ownership and assignment of policy values.
- The taxable portion of any Distribution taken before age 59 ½ may be subject to a 10% penalty by the IRS. This 10% penalty always applies if the MEC owner is not treated as a natural person for tax purposes; e.g. is a corporation or trust.
- For purposes of determining the taxable portion of Distributions, federal tax law provides that all MECs issued by the same insurance company to the same Policyowner during any calendar year shall be treated as one MEC.
- PLIC will report income relating to such Distributions to the IRS as required by federal law and regulations.

Additional Information:

- Once a policy becomes a MEC that status cannot change. Any policy received in exchange for a MEC policy will also be considered a MEC.
- For specific questions regarding the taxation of your MEC policy, please consult your tax advisor.

INITIAL HERE ☐ **By initialing here, the Policyowner confirms their understanding that the policy to be issued is now or will become a MEC at or after issue, and accepts MEC status for the policy.**

Signatures

INITIAL HERE ☐ By initialing here, the Policyowner confirms they received the Outline of Coverage, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Life Insurance Buyer's Guide, and A Shoppers Guide to Long-Term Care Insurance.

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

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

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust) have been met.

CAUTION: If your answers on this application are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

SIGNED IN:

City	State

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE **X**

Proposed Insured's Signature

SIGN HERE **X**

Policyowner's Signature, if other than Proposed Insured, and include **Title,** if Corporation, Trust, or Business Entity.

SIGN HERE **X**

Additional Policyowner's Signature & Title, if applicable

Producer's Certification

	Yes	No
1. Does the Insured have any existing life insurance or annuities, including those with LTC coverage?	☐	☐
2. Do you know or have any reason to believe that a replacement of insurance is involved?	☐	☐
3. I have discussed the appropriateness of replacement, followed applicable state laws, PLIC's written guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If No, explain on an additional sheet.)	☐	☐
4. Based upon my review of, among other things, the Policyowner's and Proposed Insured's age, income, net worth, tax and family status, and current plan of insurance, I certify that the purchase of this policy meets the Policyowner's insurance needs and financial objectives, and is consistent with PLIC's suitability standards. I have documented and will retain my suitability analysis and conclusions.	☐	☐

5. List below any other Health Insurance you have sold to the Proposed Insured that is currently in force, or purchased within the last 5 years and no longer in force. (If No, explain on an additional sheet.)

Company	Policy Number	Year of Issue	Policy Status
			☐ In force ☐ No longer in force
			☐ In force ☐ No longer in force

I have reviewed the application and all related forms with the Insured and Policyowner(s).

SIGN HERE **X**

Soliciting Producer's Signature

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

PACIFIC LIFE INSURANCE COMPANY
[45 Enterprise, Aliso Viejo, CA 92656
(800) 347-7787
www.PacificLife.com]

PACIFIC LIFE

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE

Rider Forms R11ABR and R11EBR

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

CAUTION: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application will be attached to any issued Policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy and Riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: [45 Enterprise, Aliso Viejo, CA 92656].

1. THIS POLICY AND THE RIDERS PROVIDE INDIVIDUAL COVERAGE

The Policy is a flexible premium adjustable life insurance policy with individual long-term care insurance Riders. If the base life insurance Policy is issued, the Accelerated Benefit Rider (ABR) will also be issued. The coverage under the ABR provides two years of long-term care insurance benefits by accelerating payment of the life insurance policy's face amount. The Extended Benefit Rider (EBR) is an optional purchase and provides between one and six years of additional long-term care benefits, depending on the duration elected. You may elect to purchase the Policy and ABR without purchasing the EBR. This outline of coverage describes both the ABR and the EBR (Riders). Capitalized terms used in this outline of coverage are defined in the Definitions section, starting on page 8.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Riders contain governing contractual provisions. This means that the Policy and Riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

These Riders are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS COVERAGE IS NONCANCELLABLE – This means you have the right, subject to the terms of your Policy and Riders, to continue your coverage as long as the single premium is paid. We cannot change any of the terms of your coverage on our own and cannot

require that you pay additional premium after the Riders are issued, including for any Inflation Benefit Option.

Waiver of Premium – A waiver of premium provision waives premium payments that become due when an insured is receiving benefits under the coverage. There is no waiver of premium for these Riders because there is a single premium required and it must be paid prior to the coverage being issued. After issue there are no further premiums required that could be waived.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We do not have the right to change the premium rates for your coverage. This coverage requires a single premium and it must be paid prior to the Policy and Riders being issued. After issue, you will not be required to make any additional premium payments.

6. TERMS UNDER WHICH THE POLICY AND RIDERS MAY BE RETURNED AND PREMIUM REFUNDED

The Owner has 30 days from the day the Policy and Riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and the Riders. The Policy and Riders can be returned to us at our Administrative Office or to the Producer/Representative through whom it was bought. We will refund the full amount of any premium paid within 30 days of such a Policy and Rider return and the Policy and Riders will be void from the start.

Return of Premium Benefit – The Riders each include a Return of Premium Benefit that is payable if the coverage is surrendered or lapsed. At issue, the Return of Premium Benefit is equal to the premium paid for the ABR or EBR, as shown on the Policy specifications. After issue, the Return of Premium Benefit may be reduced by withdrawals, a Terminal Illness Benefit Payment (available under the terms of the Policy) or benefit payments under the Riders, as described in the Riders.

Limited Refund on Death – Some of the premium paid for the Riders may be refunded on the death of the Insured. The amount of refunded premium, if any, will be based on the premium paid for the Riders, adjusted for any death benefit payable under the Policy, benefit payments made under the Riders, Terminal Illness Benefit Payment or withdrawals, as described in the Riders.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor our producers/representatives represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home facility, in the community, or in the home.

With the exception of the International Benefit, which applies only to the ABR, this coverage provides reimbursement benefits. Reimbursement benefits reimburse the Owner for covered long-term care expenses incurred. The International Benefit under the ABR pays indemnity benefits. Indemnity benefits pay a fixed dollar amount regardless of the amount of expenses incurred. All benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE COVERAGE

Benefits are available under the ABR up to the Monthly Maximum Benefit Amount until the Maximum ABR Benefit Limit is reached. The EBR extends most of the benefits provided by the ABR, subject to the Maximum Benefit Amount, until the Maximum EBR Benefit Limit is reached. The Non-Continual Alternative Care Benefit and the Caregiver Training Benefit are subject to lifetime maximums specific to those benefits. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits for the following Covered Expenses:

Care Coordination and Care Coordination Benefit – Care Coordination is intended to help identify an Insured's specific care needs and long-term care services and programs available to meet those needs. Care Coordination will provide the Insured with a Care Coordinator who will review the Insured's specific situation and develop Plans of Care to meet the Insured's needs. The Care Coordinator will: assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis; work with the Insured to determine the specific services the Insured requires; develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs; coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and help the Insured arrange for care.

Care Coordination provided by us does not require a claim for benefits and does not count against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Care Coordination not performed by us requires a claim for Care Coordination Benefits, which counts against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Benefits are payable for Covered Expenses the Insured incurs for Care Coordination not performed by us during the Policy month up to the Monthly Maximum Benefit Amount.

Nursing Home Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in a Nursing Home Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses also include Hospice Care provided by a Hospice Care Facility. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Nursing Home Benefit will be pro-rated.

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in an Assisted Living Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Assisted Living Facility Benefit will be pro-rated.

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care, which include the following services when provided by a

Home Health Care Agency or by an Independent Provider: Home Health Care Services; Maintenance or Personal Care Services; Hospice Care; and Respite Care. Covered Expenses also include Adult Day Care provided by an Adult Day Care Center. Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Home and Community Care Benefit will be pro-rated.

International Benefit – The International Benefit is included as part of the ABR only and is not available under the EBR. The Insured is eligible to receive the full Monthly Maximum ABR Benefit Amount when Confined in a Nursing Home Facility outside the United States. No other benefit is payable under the ABR during any Policy month for which the Insured receives the International Benefit. This cash benefit will be available beginning on the date the Insured first satisfies the Eligibility for Payment of Benefits requirements and is Confined to a Nursing Home Facility outside the United States. The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and is Confined in a Nursing Home Facility outside the United States in order to receive this benefit. For proof of this, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. The Insured must provide written proof every 90 days, in English, that the Insured is a Chronically Ill Individual. The cost for providing any proof required for this benefit is the responsibility of the Owner. We must be notified in advance to receive the International Benefit and such notice must be made in writing and in English. Each month the Insured is eligible for the International Benefit, benefits are payable in the amount of the Monthly Maximum ABR Benefit Amount. If the Insured is not a Chronically Ill Individual each day of the Policy month, the International Benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

Alternative Care Benefit – We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the Riders. Benefits and services can be authorized if we determine that they: are cost-effective; are appropriate to the Insured's needs; are consistent with general standards of care; provide the Insured with an equal or greater quality of care; and are for and constitute Qualified Long-Term Care Services. Any benefits, treatments or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician. We reserve the right to decline to authorize benefits and services. Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits.

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment up to the Non-Continual Alternative Care Benefit Lifetime Maximum.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance the Insured's ability to perform the Activities of Daily Living and allow the Insured to remain in the Insured's Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits

otherwise provided by the Riders. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

Caregiver Training Benefit – Caregiver Training Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in the Insured's Home. Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return to Home where the Insured can be cared for by the person receiving the training. Benefits are payable for the Covered Expenses the Insured incurs for Caregiver Training up to the Caregiver Training Benefit Lifetime Maximum.

Nonforfeiture Benefit of the EBR – Upon lapse of the EBR, the Owner is eligible for a Nonforfeiture Benefit of either the Return of Premium Benefit, as described above under Section 6, or a limited amount of paid-up long-term care benefits, as described in the EBR.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for benefits under the coverage, we must verify that the Insured is a Chronically Ill Individual, as certified by a Licensed Health Care Practitioner within the past 12 months. In addition:

- The cost incurred is a Covered Expense under the coverage and the service for such Covered Expense is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under the Riders must be in force on the dates the care is received;
- The Insured must not have exhausted the applicable limits on the specific benefits claimed, or the Maximum Benefit Limit;
- The Insured must meet the additional requirements for the specific benefits claimed; and
- The Insured must satisfy the applicable Elimination Period.

Long-Term Care Benefits	**Elimination Period**
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[90] Days
Care Coordination Benefit	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[90] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[90] Days

10. EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions – We will not reduce or deny any claim under the Riders because of a sickness or physical or medical condition disclosed on the application.

Non-eligible Facilities and Providers – Any facility or provider for a given benefit that does not fall within the "Definitions" section, starting on page 8, would be a non-eligible facility or provider for that benefit.

Non-eligible Levels of Care – Coverage does not include any services that do not constitute Qualified Long-Term Care Services. Care from family members is covered only where specifically indicated below in Exclusions/Exceptions and Limitations.

Exclusions/Exceptions and Limitations – We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while the Riders are not in force, except as provided in the provision.

Non-Duplication – We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in the Rider.

Duration – The ABR provides two years of long-term care benefits. The EBR provides between one and six years of additional long-term term care benefits, depending on the duration elected. These durations may increase or decrease depending on how the Policy and Rider benefits are used.

THIS COVERAGE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, consider whether and how the benefits of this coverage may be adjusted. One of the available Inflation Benefit Options may be elected at the time of purchase to increase the coverage. While the Insured will be underwritten in order to purchase the coverage, once the Inflation Benefit Option is in effect, no further underwriting is required. There is a premium charge for including any Inflation Benefit Option in the coverage. The premium charge varies depending on which Inflation Benefit Option is elected.

Unless rejected, one of the following will apply to the Riders:

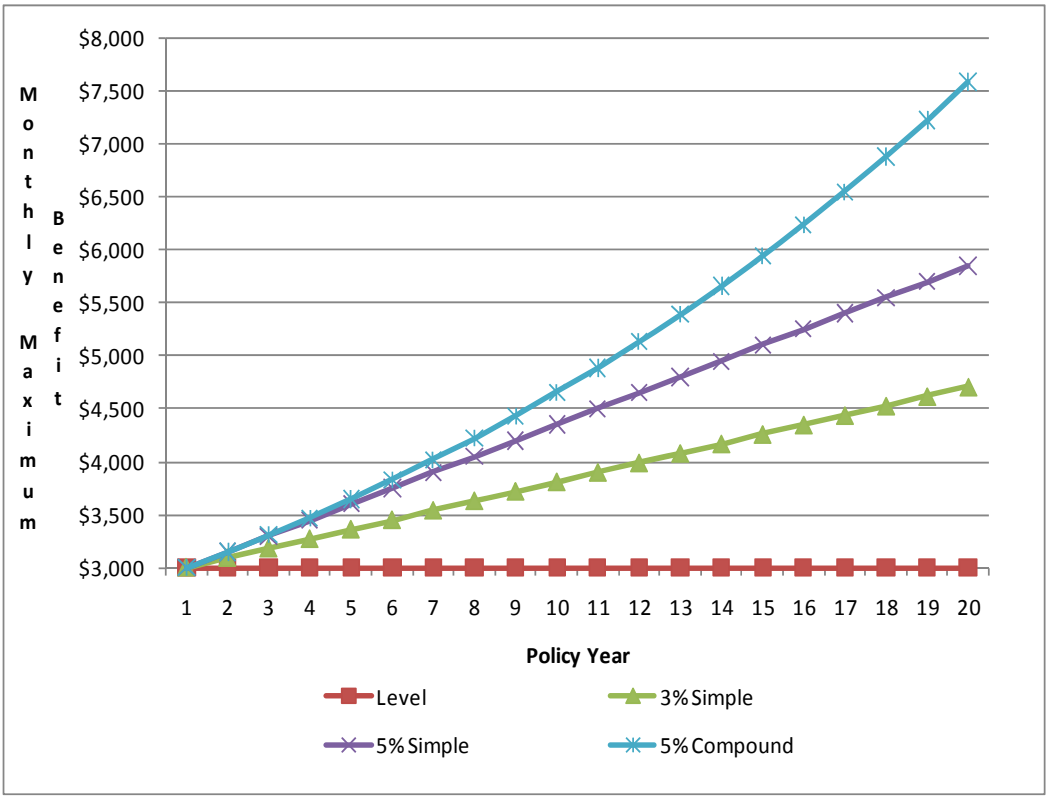
- 5% Compound Inflation Benefit Option
- 5% Simple Inflation Benefit Option
- 3% Simple Inflation Benefit Option

Simple Inflation Benefit Option (3% or 5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to the selected percentage of the initial Monthly Maximum Benefit Amount. The Maximum Benefit Limits will be increased by the same proportion as the Monthly Maximum Benefit Amount.

Compound Inflation Benefit Option (5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to 5% of the Monthly Maximum Benefit Amount in effect immediately prior to the increase. The Maximum Benefit Limits will also be increased on each Policy anniversary by an amount equal to 5% of the Maximum Benefit Limits in effect immediately prior to the increase.

INFLATION PROTECTION – GRAPHIC COMPARISONS

The following chart compares and contrasts benefit levels for coverage with no inflation protection and coverage with the 3% simple, 5% simple and 5% compound Inflation Benefit Options offered with the coverage. The chart assumes an initial Monthly Maximum Benefit Amount of $3,000.



The following chart shows a relative cost comparison of total premiums with and without an Inflation Benefit Option. At each issue age and gender combination, the chart shows the total premium with the Inflation Benefit Option divided by the total premium without the Inflation Benefit Option. For example, total premiums for a 35 year old female for coverage with the 5% simple Inflation Benefit Option will cost 163% of the total premiums for coverage with no Inflation Benefit Option. The chart assumes a 2 year ABR and 2 year EBR were elected.

Issue Age	Gender	Inflation Option for 4 Year LTC Benefit			
		None	3% Simple	5% Simple	5% Compound
35	Male	100%	117%	130%	215%
	Female	100%	131%	163%	376%
45	Male	100%	121%	140%	192%
	Female	100%	132%	163%	315%
55	Male	100%	124%	150%	173%
	Female	100%	131%	163%	257%
65	Male	100%	124%	148%	162%
	Female	100%	131%	157%	245%
75	Male	100%	121%	138%	160%
	Female	100%	145%	170%	240%

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once an Insured's application is approved, coverage is provided for an Insured who is a Chronically Ill Individual as a result of Alzheimer's disease or any related degenerative and dementing illnesses.

13. PREMIUM

The single premium for the coverage will be determined based on the amount of coverage, the Inflation Benefit Option elected, if any, and the Insured's issue age and gender as described in the application and illustrated in the chart in section 11.

14. ADDITIONAL FEATURES

Underwriting – We will underwrite the Insured's application by reviewing one or more of the following: the information submitted on the application; an attending Physician's report; copies of the Insured's medical records; a medical evaluation; a telephone interview; and an in-person interview.

Added Protection Against Lapse – If the Insured's coverage terminates due to lapse, we will provide a retroactive continuation of coverage if within five (5) months of the termination date the Insured provides us with proof the Insured was a Chronically Ill Individual, beginning on or before the termination date. All past due premiums, outstanding Policy Debt prior to the date of lapse and any amount refunded due to lapse in connection with the Rider Return of Premium Benefit must be paid. In that event, the Policy and Riders will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE COVERAGE.

DEFINITIONS

In this section, we define certain terms used throughout this Outline of coverage. Defined terms are usually capitalized to show emphasis.

ABR – means the Accelerated Benefit Rider.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that has the appropriate state licensure or certification as an Assisted Living Facility where required. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;

- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under the ABR or EBR. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

EBR – means the Extended Benefit Rider.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or experience to provide such care. If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:

- Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;

- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and
- Provide ongoing supervision and training to its employees appropriate to the services to be provided.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit Limit – is the total amount of lifetime benefits payable under the ABR or EBR, as applicable, as described in the ABR or EBR.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum Benefit Amount – is the total amount of monthly benefits payable under the ABR or EBR, as applicable.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services.

Policy – means the flexible premium adjustable life insurance policy Form ICC11 P11PPC to which the Riders are attached.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Riders – means the ABR and the EBR.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

Terminal Illness Benefit Payment – means the actual dollar amount of benefit received under the Terminal Illness Benefit of the Policy.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

AUTHORIZATION TO OBTAIN INFORMATION

This authorization complies with HIPAA Privacy Rules.

PROPOSED INSURED

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

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

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

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

SIGNATURES

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

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

SIGN HERE **X** _____
Proposed Insured's Signature (or parent/guardian if under age 16)

SIGN HERE **X** _____
Proposed Additional Insured's Signature (or parent/guardian if under age 16)

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DISCLOSURE NOTICE - HOW WE USE YOUR INFORMATION

DETACH AND LEAVE WITH PROPOSED INSURED(S)

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

Application and Medical Records – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or MIB, Inc. ("MIB", see below). When we do so, we will use the Authorization To Obtain Information that you signed. The purpose of MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability.

MIB, Inc. – Information regarding your insurability will be treated as confidential. PLIC or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have about you in its file. Please contact MIB at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

PLIC, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com].

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

DISCLOSURE TO OTHERS

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

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

DISCLOSURE TO YOU

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

PACIFIC LIFE INSURANCE COMPANY
Express Mail to: Life Insurance Operations Center
1299 Farnam Street 4th Floor, Omaha, NE 68102
Fax to: (866) 964-4860 • (800) 347-7787 • www.PacificLife.com

PACIFIC PREMIERCARE TICKET

1. PROPOSED INSURED INFORMATION

First Name ____ MI ____ Last Name ____ Other names used in last 5 years ____

Address: Street ____ City ____ State ____ Zip Code ____

Date of Birth ____ Place of Birth (State/Country) ____ SSN ____ E-mail Address ____

Gender: ☐ Male ☐ Female Cigarette Smoker: ☐ No ☐ Yes

Married (or in a civil union or domestic partnership)? ☐ No ☐ Yes
If "yes" and spouse/partner will also apply for Pacific PremierCare, provide their name: ____

2. INTERVIEW CONTACT INFORMATION (Telephone # where Proposed Insured can be reached.)

Primary Number ____ Alternate Number ____ Best time to call for interview: ☐ Morning ☐ Afternoon ☐ Evening

3. POLICY INFORMATION

The Policyowner will sign the Application for Pacific PremierCare in the state of ____

Policyowner Name (If other than Proposed Insured) ____ SSN/TIN ____

Relationship To Proposed Insured ____ Policyowner E-mail Address ____

Primary Beneficiary Name ____ % Share ____ Relationship To Proposed Insured ____ Date of Trust ____

Primary Beneficiary Name ____ % Share ____ Relationship To Proposed Insured ____ Date of Trust ____

$____ Single Premium Amount

Is a Temporary Insurance Agreement (TIA) submitted with this Ticket? ☐ No ☐ Yes
Amount Submitted $____

Long-Term Care (LTC) Benefit Duration: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years ☐ 7 Years ☐ 8 Years

Inflation Benefit Option: ☐ 3% Simple ☐ 5% Simple ☐ 5% Compound ☐ Reject All Inflation Benefit Options

4. EXISTING INSURANCE AND REPLACEMENT INFORMATION

Any existing life or annuity coverage, including those with LTC coverage? ☐ No ☐ Yes

Any Replacements? (Check all that apply) ☐ Life* ☐ Annuity ☐ LTC ☐ Health

Any 1035 Exchanges? ☐ No ☐ Yes

If any "Yes" answers or any policies being replaced, complete applicable replacement and 1035 Absolute Assignment forms.

*If replacing a variable life or annuity contract, I certify that I have the appropriate variable state licenses.

5. COMMISSION AND CASE CONTACT INFORMATION (Use additional sheet if more than 2 Producers. Telephone # and E-mail address are needed to communicate with you throughout the process.)

Producer's Name First MI Last (Print)	SSN/TIN	SAID Code	Commission %

Contact Name (If other than producer)	Telephone # (Required)	Fax #	E-mail Address (Required)

6. SIGNATURE

☐ I have personally met with and verified the identity of the Proposed Insured by reviewing valid forms of identification.

☐ I reviewed the pre-qualifying questionnaire with the Proposed Insured and confirmed the Proposed Insured is a good candidate for Pacific PremierCare.

☐ I will deliver the Outline of Coverage, Things You Should Know Before You Buy Long-Term Care Insurance, Disclosure Notice, Privacy Notice — Health (HIPAA), Life Insurance Buyers Guide, A LTC Shoppers Guide and, if applicable, Important Notice for Active Duty Members of the United States Armed Forces.

SIGN HERE X ____
Producer's Signature

____
Date (mm/dd/yyyy)

PACIFIC LIFE

LONG-TERM CARE INSURANCE SUITABILITY

[Pacific Life Insurance Company
Life Insurance Operations Center
P.O. Box 2030, Omaha, Nebraska 68103-2030
Tel (800) 347-7787, Fax (866) 398-0467, www.PacificLife.com]

[Current Date]

Servicing Producer: [Producer Phone #]

[Policyowner Name]
[Address 1]
[Address 2]
[City State Zip]

[Producer Name]
[Address 1]
[Address 2]
[City State Zip]

Proposed Insured's Name:
Reference Number:

Your recent request for [Pacific PremierCare], a Flexible Premium Adjustable Life Insurance Policy with long-term care insurance rider(s), included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your request, to avoid selling coverage to those who may not need it.

You have either chosen not to provide any financial information for us to review or your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your request, including the booklet "A Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before You Buy Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this coverage.

We have suspended our review of your request. If, after careful consideration, you still believe this coverage is what you want, check the appropriate box below and return this letter to us within the next **60** days. We will then continue reviewing your request and issue coverage if you meet our underwriting criteria.

If we do not hear from you within the next 60 days, we will close your file and not issue coverage. You should understand that you will not have any coverage until we hear back from you, approve your request and issue you a policy.

If you would like more information, please contact your servicing producer as specified above.

Life Insurance Operations Center
New Business Services

Please check one box and return in the enclosed envelope or fax to number listed above.

- ☐ **Yes**, that's right. I have chosen not to provide any financial information for review but I still wish to purchase this coverage. Please resume review of my request.
- ☐ **Yes**, although my worksheet indicates that long-term care insurance may not be a suitable purchase, I wish to purchase this coverage. Please resume review of my request.
- ☐ **No**. I have decided not to buy coverage at this time.

X _____ _____ _____

Policyowner's Signature **Print Policyowner's Name: First MI Last** **Date**

PACIFIC LIFE INSURANCE COMPANY
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www.PacificLife.com]

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or your producer gives you a copy of a book called the National Association of Insurance Commissioners' "A Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. For more information about the senior health insurance counseling program in your state, contact the state agency listed in the Directories in the above mentioned Shopper’s Guide To Long-Term Care Insurance.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

PRIVACY NOTICE FOR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You have received this notice because you have applied for, or have life insurance coverage with Pacific Life Insurance Company ("PLIC") that contains a long-term care benefit. It is the goal of PLIC to protect the privacy of its policyowners and we are committed to protecting the confidentiality and security of information we collect about you--especially health information.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on covered entities concerning the use and disclosure of individual health information. This information, known as protected health information ("PHI"), applies to all forms of an individual's PHI, whether electronic, written, or oral. PHI includes individually identifiable information that relates to your past, present or future health, treatment, or payment for health care services.

PLIC's Duties With Respect to Health Information About You

PLIC will collect, use and disclose information about you to evaluate and process any requests for coverage and claims for benefits you make regarding your long-term care benefit. In accordance with the HIPAA Privacy Rule, PLIC is required by law to maintain the privacy of your PHI; to provide you this notice of our legal duties and privacy practices with respect to your PHI; and to follow the terms of this notice.

PLIC reserves the right to change the terms of this notice. Any changes will apply to all PHI PLIC already has about you as well as any PHI we may receive in the future. Within 60 days of any material change to this notice, PLIC will promptly send the revised privacy notice to you should PLIC still maintain PHI about you when the revised notice becomes effective.

How PLIC May Use or Disclose Your Health Information

The privacy rule generally allows the use and disclosure of your PHI without your permission (known as an authorization) for purposes of health care treatment activities, payment activities and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referral between providers. *For example, PLIC may share health information about you with physicians who are treating you.*
- **Payment** includes activities by PLIC to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" functions such as risk assessment and collection. *For example, PLIC may share information about your coverage or the expenses you have incurred with a health care facility in order to coordinate payment of benefits.*

- **Health Care Operations** include activities by PLIC such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, and reinsurance, arranging for medical review and audit activities, and business planning and development. PLIC may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. *For example, PLIC may use information about your claims to review the effectiveness of wellness programs.*
- **Business Associates** includes PHI that PLIC may disclose to non-affiliated business associates, but only if the receipt of PHI is necessary for the business associate to provide a service to us and the business associate agrees to protect the PHI according to HIPAA rules. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies, and companies that provide general administrative services.

The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, your health information can be disclosed without an authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without an authorization to your legal representative. PLIC is also allowed to use or disclose your health information without your written authorization in the following special circumstances:

- As required by law
- Public health activities
- Reports to appropriate authorities concerning victims of abuse, neglect, or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Regarding decedents for identity, cause of death, or as allowed by law, to coroners, medical examiners, and funeral directors
- Cadaveric organ, eye, or tissue donation
- Research
- To avert serious threat to health or safety
- Specialized Government Function, including national security and intelligence activities
- Workers' Compensation

If your state has a privacy law that provides you greater protections, PLIC will comply with that law. Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if PLIC has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures PLIC has already made.

Your Individual Rights

You have the following rights with respect to your health information that PLIC maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and PLIC's right to refuse

You have the right to ask PLIC to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask PLIC to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask PLIC to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to PLIC must be in writing.

PLIC is not required to agree to a requested restriction. And if PLIC does agree, a restriction may later be terminated by your written request, by agreement between you and PLIC (including an oral agreement), or unilaterally by PLIC for health information created or received after you are notified that PLIC has removed the restrictions. PLIC may also disclose health information about you if you need emergency treatment, even if PLIC has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, PLIC will accommodate reasonable requests for you to receive communications of health information from PLIC by alternative means or at alternative locations.

If you want to exercise this right, your request to PLIC must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information maintained in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records PLIC uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, PLIC may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to PLIC must be made in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), PLIC will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which PLIC expects to address your request.

PLIC may provide you with a summary or explanation of the information instead of access to or copies of your health information if you agree in advance and pay any applicable fees. PLIC may also charge reasonable fees for copies or postage.

If PLIC does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that PLIC amend your health information in a designated record set. PLIC may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by PLIC (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to PLIC must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, PLIC will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which PLIC expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures PLIC has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to PLIC must be in writing. Within 60 days of the request, PLIC will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which PLIC expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but PLIC may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from PLIC upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Right to file a complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit a written complaint addressed and sent to the [PLIC Privacy Office], as indicated in the below paragraph. PLIC will not retaliate against you for filing a complaint.

PLIC Privacy Office

For more information on PLIC's privacy policies or your rights under HIPAA you may contact the [PLIC Privacy Office] by mail at: [Pacific Life Insurance Company Privacy Office, 700 Newport Center Drive, Newport Beach, CA 92660 or toll free (877) 722-7848].

Effective Date: [November 1, 2011]

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

PACIFIC LIFE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual life insurance policy providing long-term care insurance benefits to be issued by Pacific Life Insurance Company (PLIC). Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for PLIC to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Date (mm/dd/yyyy)

SIGN HERE

X

Producer's Signature

Producer's Name: First MI Last (print)

Producer Address: Street City State Zip Code

THE ABOVE "NOTICE TO APPLICANT" WAS DELIVERED TO ME ON:

Date (mm/dd/yyyy)

SIGN HERE

X

Applicant's Signature include **Title,** if Corporation, Trust, or Business Entity

Applicant Name: First MI Last (If other than Proposed Insured)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

AUTHORIZATION TO RELEASE INFORMATION

For Individual Life Insurance with Long-Term Care (LTC) Benefits.

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

1. I authorize any physician, health care professional, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, information database manager, other medical or medically related facility, insurance company, health plan, MIB, Inc., consumer reporting agency, state motor vehicle agency, or employer to release to **Pacific Life Insurance Company (PLIC)** its subsidiaries, reinsurers, employees and representatives, any protected health information ("PHI") they may have in their possession or under their control as to the diagnosis, treatment, prognosis of any physical or mental condition (excluding psychotherapy notes), human immunodeficiency virus (HIV) infection, sexually transmitted diseases, treatment of mental illness, and the use of tobacco. Although Federal Regulation protects information related to drug or alcohol abuse from disclosure, I give permission to collect this information. I understand that the reason for releasing such PHI under this paragraph 1 is to determine eligibility for the purchase and administration of a life insurance/long term care policy ("Policy") and that such information will not be released to any person or organization except a reinsurer, MIB, Inc., and other persons or organizations performing business or legal services on behalf of PLIC in connection with my application, or as may be otherwise required by law, authorized under paragraph 2 below, or as I may further authorize.

2. I also authorize PLIC and its subsidiaries, reinsurers, employees and representatives, to release to the policyowner(s) of the Policy or the assignee or duly authorized attorney-in-fact of the policyowner(s), the producer of record of the Policy, and to the additional authorized recipient I have indicated above, if any, any and all PHI relating to the Policy ("Policy Information") including but not limited to the Policy's values, any withdrawals taken against the Policy, payments for long-term care services, and information required by law to be provided to the policyowner(s). I understand that the reason for releasing Policy Information under this paragraph 2 is to facilitate the administration of the Policy or as is required by law.

3. I understand that I may revoke this authorization at any time by sending a written revocation request to Pacific Life Insurance Company at: [P. O. Box 2030, Omaha, NE 68103-2030]. Such a revocation will not affect (a) any action taken or information released prior to the revocation, (b) any legal right PLIC has to contest the Policy, or to contest a claim under the Policy, (c) any information necessary to service and administer the Policy, or (d) Policy Information that PLIC is required by law to provide to the policyowner(s) . I understand that if I revoke or refuse to sign this authorization, PLIC may not be able to process my application.

4. I understand that PLIC may not condition treatment, payment, or eligibility for benefits on whether I sign this authorization, but PLIC may require that I sign this authorization in the event that I am not both the policyowner and the insured. This authorization is not affected or limited by any prior agreements I may have made with any of the above persons or entities to restrict the release of such information, and I instruct them to release and disclose all such information without restriction. This authorization shall remain in force for as long as the Policy is in force, and a copy of this authorization is as valid as the original. I understand that once any such health-related information is released pursuant to this authorization, that information may be redisclosed and will no longer be covered or protected by the HIPAA rules governing privacy and confidentiality of health information.

SIGNATURES

I acknowledge that I have received a copy of this authorization.

Signed and Dated by the Insured in: _____ **City** _____ **State** _____ **Date** (mm/dd/yyyy)

SIGN HERE **X** _____
Proposed Insured's Signature

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy. All references to "you" on this form apply to the policyowner(s). (Complete one form per policyowner.)

PREMIUM INFORMATION

Policy and Rider Form Numbers: [P11PPC – Flexible Premium Adjustable Life Insurance Policy
R11ABR – Accelerated Benefit Rider
R11EBR – Extended Benefit Rider]

The premium for the coverage you are considering will be a one-time single premium of $_____.

Type of Policy: Non-Cancellable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

The company cannot raise your rates on this policy.

RATE INCREASE HISTORY

The company has sold long-term care insurance since 2012 and this policy form since [2012]. The company has never raised its rates for any long-term care policy it has sold.

SOURCE OF PREMIUM

How will you pay for this policy? (Check all that apply)

☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

QUESTIONS RELATED TO YOUR INCOME

What is your annual income? (Check one)

[☐ Under $10,000 ☐ $20,000 - $49,999 ☐ $100,000 - $149,999]

[☐ $10,000 - $19,999 ☐ $50,000 - $99,999 ☐ $150,000 and over]

How do you expect your income to change over the next 10 years?

☐ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Questions Related to Your Income (Continued)

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount? (Check all that apply) ☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

The national average annual cost of nursing home care in [2009] was [$72,270], but this figure varies across the country. In ten years the national average annual cost would be about [$117,800] if costs increase 5% annually. [(Source: National Long-Term Care Clearinghouse, 2009.)]

The elimination period for nursing home care under the rider is [90] days. Based on the year [2009] figures provided above, this means approximately [$18,069] in nursing home costs will be incurred before benefits are payable.

How are you planning to pay for your care during the elimination period? (Check all that apply)
☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home and premium for this policy, about how much are all of your assets (your savings and investments) worth?

[☐ Under $20,000 ☐ $30,000 - $49,999 ☐ $100,000 - $249,999 ☐ $500,000 and over]

[☐ $20,000 - $29,999 ☐ $50,000 - $99,999 ☐ $250,000 - $499,999]

How do you expect your assets to change over the next ten years? (Check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statements

Check one:	☐ The answers to the questions above describe my financial situation. or ☐ I choose not to complete this information.

☐ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. (This box must be checked.)

Signatures

SIGN HERE X _____ Date (mm/dd/yyyy)

Policyowner's Signature

Policyowner's Name: First MI Last (print)

☐ I explained to the policyowner the importance of completing this information.

SIGN HERE X _____ Date (mm/dd/yyyy)

Producer's Signature

Policyowner's Name: First MI Last (print)

Sign below only if your producer has advised you that this policy may not be suitable for you.

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

SIGN HERE X _____ **Date** (mm/dd/yyyy)

Policyowner's Signature

The company may contact you to verify your answers.

Statement of Variability
Policy Form A11PPC

Location	Factor	Sample Value	Range	Conditions
Page 1	Administrative Office Address & Website	Life Insurance Operations Center P.O. Box 2030 • Omaha, NE 68103-2030 (800) 347-7787 • Fax (866) 964-4860 www.PacificLife.com	Administrative office	Changes only when there are changes to the administrative office location, phone numbers, and website address
Page 1, Page 6	Marketing Name	Pacific PremierCare	Marketing name of LTC product. At this time, only Pacific PremierCare will be marketed and sold	Changes only when marketing name changes

Statement of Variability
Policy Form A11SOH

Location	Factor	Sample Value	Range	Conditions
Page 1	Administrative Office Address & Website	Life Insurance Operations Center P.O. Box 2030 • Omaha, NE 68103-2030 (800) 347-7787 • Fax (866) 964-4860 www.PacificLife.com	Administrative office	Changes only when there are changes to the administrative office location, phone numbers, and website address
Page 1	Marketing Name	Pacific PremierCare	Marketing name of LTC product. At this time, only Pacific PremierCare will be marketed and sold	Changes only when marketing name changes

Statement of Variability
Policy Form A11TIA

Location	Factor	Sample Value	Range	Conditions
Page 1	Administrative Office Address & website	Life Insurance Operations Center P.O. Box 2030 • Omaha, NE 68103-2030 (800) 347-7787 • Fax (866) 964-4860 www.PacificLife.com	Administrative office	Changes only when there are changes to the administrative office location, phone numbers, and website address
Page 1	Marketing Name	Pacific PremierCare	Marketing name of LTC product. At this time, only Pacific PremierCare will be marketed and sold	Changes only when marketing name changes

Statement of Variability
Policy Form E11LRD

Location	Factor	Sample Value	Range	Conditions
Page 1	Officers	James T. Morris Jane M. Guon	Officer's signatures	Reflects the current holders of the titles indicated below
Cover	Company contact information	www.PacificLife.com, (800) 347-7787	Web site and telephone number	Company's current Web site address and telephone number will be reflected

Statement of Variability
Policy Form R11ABR

Location	Factor	Sample Value	Range	Conditions
Cover	State Department of Insurance Phone Number	STATE (XXX) XXX-XXXX	One of 50 states and D.C. Dept. of Ins. phone number of one of 50 states and D.C.	Administrative system assigns based on state where policy is issued
Cover	Officers	James T. Morris Jane M. Guon	Officer's signatures	Reflects the current holders of the titles indicated below
Cover	Company contact information	www.PacificLife.com, (800) 347-7787	Web site and telephone number	Company's current Web site address and telephone number will be reflected
Cover	Company contact information	www.PacificLife.com, (800) 347-7787	Web site and telephone number	Company's current Web site address and telephone number will be reflected

Statement of Variability
Policy Form R11EBR

Location	Factor	Sample Value	Range	Conditions
Cover	State Department of Insurance Phone Number	STATE (XXX) XXX-XXXX	One of 50 states and D.C. Dept. of Ins. phone number of one of 50 states and D.C.	Administrative system assigns based on state where policy is issued
Cover	Officers	James T. Morris Jane M. Guon	Officer's signatures	Reflects the current holders of the titles indicated below
Cover	Company contact information	www.PacificLife.com, (800) 347-7787	Web site and telephone number	Company's current Web site address and telephone number will be reflected
Cover	Company contact information	www.PacificLife.com, (800) 347-7787	Web site and telephone number	Company's current Web site address and telephone number will be reflected

Statement of Variability
Policy Form A11AVT

Location	Factor	Sample Value	Range	Conditions
Page 1	Policy Number	LTC9999990	Administrative system assigns	Administrative system assigned
Page 1	Insured	Jane Doe	Insured's name	Owner's choice
Page 1	Officers	James T. Morris Jane M. Guon	Officer's signatures	Reflects the current holders of the titles indicated below

Statement of Variability
Policy Form N11OOC

Location	Factor	Sample Value	Range	Conditions
Page 1	Company contact information	45 Enterprise, Aliso Viejo, CA 92656 (800) 347-7787 www.PacificLife.com	Company address, web site, telephone number	Reflects the current address, web site and phone number of company
Page 4	LTC Benefits Alternative Care Benefit Assisted Living Facility Benefit Caregiver Training Benefit Home and Comm. Care Bene. International Benefit Non-Contin. Alt. Care Benefit Nursing Home Benefit	0 Days 90 Days 0 Days 0 Days 90 Days 0 Days 90 Days	0-90 days	May change after an actuarial pricing evaluation. Any such change will apply to new issues

Statement of Variability
Policy Form P11PPC

	Factor	Sample Value	Range	Conditions
Cover	Company contact information	45 Enterprise, Aliso Viejo, CA 92656, www.pacificlife.com, (800) 347-7787.	Company address, web site, telephone number	Reflects the current address, web site and phone number of company
Cover	Officers	James T. Morris Jane M. Guon	Signatures of officers	Reflects the current holders of the titles indicated below the signatures
Cover	Insured	Jane Doe	Insured's name	Owner's choice
Cover	Owner	Leland Stanford	Owner's name	Owner's choice
Cover	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Cover	Policy Date	November 1, 2011	Date policy is in force	Administrative system assigns
Cover	State Department of Insurance Phone Number	STATE (XXX) XXX-XXXX	One of 50 states and D.C. Dept. of Ins. phone number of one of 50 states and D.C.	Administrative system assigns based on state where policy is issued
Cover	Marketing Name	PPC	Marketing abbreviation	Marketing decision
Page 3.0	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 3.0	Extended Benefit Rider	R11EBR Extended Benefit Rider	Present or not present	Owner's choice
Page 3.0	Insured	Jane Doe	Insured's name	Owner's choice
Page 3.0	Owner	Leland Stanford	Owner's name	Owner's choice
Page 3.0	Policy Date	November 1, 2011	Date policy is in force	Administrative system assigns
Page 3.0	Sex and Age	Female 35	Male and Female Issue ages 30-75	Administrative system assigns
Page 3.0	Risk Class	Nonsmoker with Couples Discount	Smoker or Nonsmoker Couples Discount displays only when a couples discount is assigned. It does not display when there is not a couples discount	Underwriter assigns
Page 3.0	Net Amount at Risk Factor	1.0029919	1.001652 to 1.004868	May change after an actuarial pricing evaluation. Any such change will apply to new issues.

Location	Factor	Sample Value	Range	Conditions
Page 3.0	MEC Status	This Policy is a Modified Endowment Contract	This phrase will display if the policy is a MEC, according to Code Section 7702A. Nothing will display if the policy is not a MEC according to Code Section 7702A	System calculates
Page 3.0	7 Pay Premium	7 Pay Premium $1,416.00	The 7 Pay Premium will display only if the policy is not a MEC. If the policy is a MEC, the 7 Pay Premium will not display	System calculates
Page 3.0	Guaranteed Annual Interest Rate	3.65%	2% to 6% If the GAIR changes within this range, we will submit the change for IIPRC review.	Market conditions may require rate to be adjusted. Any such change will apply to new issues.
Page 3.0	Table of Surrender Charge Factors	Initial Amount - $757.00 Reduction Factor - $151.40	These amounts vary by issue age, gender and risk class	System calculates
Page 3.0	Surrender Charge Periods	Level 5 Years Surrender Charge Period 10 Years	0 to 20 years	May change after an actuarial pricing evaluation. Any such change will apply to new issues.
Page 3.0	Maximum Monthly Coverage Charge	$16.88 $0.00	These amounts vary by issue age, gender and risk class	System calculates
Page 3.1	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 3.1	Face Amount (Life Coverage)	$50,000	Minimum is $50,000 Maximum is $600,000, based on reinsurance	Owner's choice

Location	Factor	Sample Value	Range	Conditions
Page 3.1	Limited Refund on Death		The Limited Refund on Death will be present or not present. It will be present if the premium paid is greater than the Death Proceeds. The following will display on the specifications page: Limited Refund on Death $XX,XXX The Limited Refund on Death will be zero unless the total premium (Life + ABR + EBR) is greater than the policy Death Proceeds. This will typically only apply at older ages with one of the inflation options	System Calculates
Page 3.1	Death Proceeds	$50,000	This amount is the total of the Face Amount	System calculates
Page 3.1	Life Coverage	$12,084.50	This is a single premium based on the filed premium rates	System calculates
Page 3.1	Accelerated Benefit Rider (ABR)	$3,143.50	This is a single premium based on the filed premium rates	System calculates
Page 3.1	Extended Benefit Rider (EBR)	$3,520.00	This is a single premium based on the filed premium rates. This amount displays only if the owner applies for the EBR rider	System calculates
Page 3.1	Total Premium	$18,748.00	The sum of Life Coverage and Rider premiums	System calculates
Page 3.1	Return of Premium Benefit	$18,748.00	The total of all premiums	System calculates
Page 3.1	Maximum ABR Benefit Limit	$50,000.00	Maximum amount that can be paid during the entire benefit period. This includes benefits subject to the Maximum Monthly ABR Benefit as well as benefits paid for Caregiver Training, Home Modification or Durable Medical Equipment	System calculates

Location	Factor	Sample Value	Range	Conditions
Page 3.1	Maximum EBR Benefit Limit	4 Years $100,000	1-6 years This includes benefits subject to Maximum Monthly EBR Benefit as well as benefits paid for Caregiver Training, Home Modification or Durable Medical Equipment	Owner's choice Maximum calculated by the system
Page 3.1	Minimum Automatic Inflation Benefit	$11,250.00	This benefit is optional and displays only if the owner applies for this	Owner's choice
Page 3.1	Total Long Term Care Benefit	6 Years	2-8 years	Owner's choice
Page 3.1	Total Long Term Care Benefit	$161,250.00	This is the sum of the benefit amounts listed above this total	System calculates
Page 3.1	Monthly Maximum ABR[and EBR] Benefit Amount	$2,083.33	EBR displays only if the owner applied for this benefit. If not applied for, the words 'and EBR' will not display. The benefit amount is the result of the ABR Benefit Limit divided by the number of months of the ABR Benefit Duration.	System calculates
Page 3.1	Automatic Inflation Option	Rejected 3% Simple	Displays Rejected if the owner does not apply for this option. If owner applies for this option, one of the following will display: 3% Simple 5% Simple 5% Compound	Owner's choice
Page 3.1	LTC Benefits Alternative Care Benefit Assisted Living Facility Benefit Caregiver Training Benefit Home and Comm. Care Bene. International Benefit Non-Contin. Alt. Care Benefit Nursing Home Benefit	0 Days 90 Days 0 Days 0 Days 90 Days 0 Days 90 Days	0-90 days The maximum elimination periods will be no greater than the periods listed in the IIPRC Member State Information for Individual Long-Term Care Insurance Uniform Standards chart	May change after an actuarial pricing evaluation. Any such change will apply to new issues.

Location	Factor	Sample Value	Range	Conditions
Page 3.1	Non-Continual Alternative Care Benefit Lifetime Maximum Caregiver Training Benefit Lifetime Maxiumum	and EBR	Present or not, depending whether the owner applied for EBR	Administrative system adds
Page 4.0	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 4.0	Insured	Jane Doe	Insured's name	Owner's choice
Page 4.0	Table of COI Rates for Life Coverage	2001 CSO Mortality Table	Monthly Rate varies, based upon Risk Class. Note: Guaranteed COI rates based upon 2001 CSO mortality table	System calculates

Pacific Life Insurance Company • [45 Enterprise • Aliso Viejo, CA 92656]
[www.PacificLife.com (800) 347-7787]

READ YOUR POLICY CAREFULLY. This is a legal contract between you, the Owner, and us, Pacific Life Insurance Company, a stock insurance company. We agree to pay the benefits of this policy according to its provisions. The consideration for this policy is the Application for it, a copy of which is attached, and payment of the initial premium.

The method for determining the Death Benefit is described in the Death Benefit section of this policy. The amount of the Death Benefit may decrease as a result of withdrawals or paid policy or rider benefits.

Premiums are flexible, subject to minimums required to keep the policy In Force. It is possible that, due to loans against the policy Accumulated Value, the policy may not continue In Force; that is, it may lapse before any Death Benefit is payable on the death of the Insured.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Benefit Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**
- **Terminal Illness Benefit (Accelerated Death Benefit)**

Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Number:	[LTC6999990]
Policy Date:	[November 1, 2011]

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Free Look Right – The Owner has 30 days from the day the policy and any riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the policy and riders. The policy and riders can be returned to us at our Administrative Office or to the Producer through whom they were bought. We will refund, directly to the payer, the full amount of any premium paid within 30 days of such a return and the policy and any riders will be void from the start.

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POLICY SPECIFICATIONS

Summary of Coverages Effective on the Policy Date

P11PPC	Flexible Premium Adjustable Life Insurance (Life Coverage)
R11ABR	Accelerated Benefit Rider (“ABR”) for Long-Term Care
[R11EBR	Extended Benefit Rider (“EBR”) for Long-Term Care]

Life Policy:	Flexible Premium Adjustable Life Insurance
Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Date:	[November 1, 2011]
Sex And Age:	[Female 35]
Risk Class:	[Nonsmoker] [with Couples Discount]
Death Benefit Qualification Test:	Cash Value Accumulation Test
Net Amount at Risk Factor:	[1.~~00327370~~0029919]
[This Policy Is a Modified Endowment Contract]	
[7 Pay Premium:	$1,416.00]
Guaranteed Annual Interest Rate:	[~~4.0~~3.65%]
Monthly Deduction End Date:	Policy Anniversary When the Insured Attains Age 95
Surrender Charge	
Initial Amount:	[$757.00]
Level Period:	[5] Years
Reduction Factor:	[$151.40]
Surrender Charge Period:	[10] Years
Maximum Monthly Coverage Charge	
Years 1 -10:	[$16.88]
Year 11 +:	[$0.00]

Summary of Values Effective on the Policy Date

Death Proceeds (Before Minimum Death Benefit)	**Benefit Amount**
Face Amount (Life Coverage):	[$50,000.00]
Death Proceeds:	[$50,000.00]

Coverage Type	**Premium Amount**
Life Coverage:	[$~~10,383.00~~12,081.50]
Accelerated Benefit Rider (ABR):	[$3,143.50]
[Extended Benefit Rider (EBR):]	[$3,520.00]
Total Premium:	[$~~17,046.50~~18,748.00]
Return of Premium Benefit:	[$~~17,046.50~~18,748.00]

Long-Term Care Benefit Limits	**Elected Benefit Duration**	**Benefit Amount**
Maximum ABR Benefit Limit:	2 Years	[$50,000.00]
[Maximum EBR Benefit Limit:]	[4 Years]	[$100,000.00]
[Minimum Inflation Benefit Option:]		[11,250.00]
Total Long-Term Care Benefit:	[6 Years]	[$161,250.00]
Monthly Maximum ABR [and EBR] Benefit Amount:		[$2,083.33]
Inflation Benefit Option for ABR [and EBR]:		[Rejected] [3% Simple]

Long-Term Care Benefits	**Elimination Period**
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[~~30~~90] Days
Care Coordination Benefit:	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[~~30~~90] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[~~30~~90] Days

Non-Continual Alternative Care Benefit Lifetime Maximum – Lesser of $5,000 or Monthly Maximum ABR Benefit Amount at time of policy issue while covered under ABR [and EBR].

Caregiver Training Benefit Lifetime Maximum – $1,000 for the Caregiver Training Benefit while covered under ABR [and EBR].

For questions about your policy or to discuss policy and rider benefits, you may contact us at our Administrative Office at (800) 347-7787or at www.PacificLife.com.

TABLE OF COST OF INSURANCE RATES

FOR LIFE COVERAGE

INSURED: [JANE DOE]

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

POLICY YEAR	MONTHLY RATE	POLICY YEAR	MONTHLY RATE
[1	0.07670	45	3.43850
2	0.08250	46	3.82530
3	0.08750	47	4.30290
4	0.09170	48	4.81110
5	0.09670	49	5.34790
6	0.10260	50	5.95010
7	0.10920	51	6.56440
8	0.11670	52	7.29570
9	0.12590	53	8.20720
10	0.13680	54	9.17860
11	0.14930	55	10.15600
12	0.16430	56	10.88250
13	0.18180	57	11.58260
14	0.20110	58	12.75540
15	0.22280	59	14.36970
16	0.24700	60	16.42160
17	0.27460	61+	0.00000]
18	0.30550		
19	0.33810		
20	0.37240		
21	0.41180		
22	0.45450		
23	0.49970		
24	0.54660		
25	0.59440		
26	0.64480		
27	0.70020		
28	0.75900		
29	0.82120		
30	0.88930		
31	0.96510		
32	1.04770		
33	1.13960		
34	1.24180		
35	1.35340		
36	1.47950		
37	1.62360		
38	1.78150		
39	1.95420		
40	2.14600		
41	2.35700		
42	2.58910		
43	2.84660		
44	3.12830		

DEFINITIONS

In this section, we define certain terms used throughout this policy. Other terms may be defined in other parts of the policy. Defined terms are usually capitalized to provide emphasis.

Accumulated Value – is the sum of Net Premiums and credited interest less withdrawals, monthly deductions, and any reductions due to the Terminal Illness Benefit Payment or benefit payments under a rider. See the Accumulated Value and Policy Loan sections for details.

Administrative Office – is the office that administers your policy. The mailing address of the Administrative Office at the time you applied for this policy is shown in the heading of the Application. If the address changes, we will send you written notice of the new address.

Age – means the age as of the Insured's birthday prior to the Policy Date, increased by the number of complete policy years elapsed.

Application – consists of the application for this policy, including any Statement of Good Health and Insurability, amendments, endorsements, and any application for reinstatement.

Class – is used in determining policy charges and interest credited, and depends on a number of factors, including (but not limited to) the Death Benefit, Face Amount, Policy Date, policy duration, the Insured's Age and Risk Class and the presence of optional riders and benefits.

Code – is the U.S. Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

Evidence of Insurability – is information, including medical information, that is used to determine insurability and the Insured's Risk Class, subject to our approval.

Face Amount – is the Face Amount of Life Coverage as shown in the Policy Specifications.

Insured – is the person insured under this policy, as shown in the Policy Specifications.

In Force – means a policy is in effect and provides a Death Benefit or Residual Death Benefit on the Insured.

Life Coverage – is insurance coverage on the Insured provided by this policy as shown in the Policy Specifications, rather than coverage provided by rider.

Monthly Deduction End Date – is shown in the Policy Specifications and is the date when Monthly Deductions end.

Monthly Payment Date – is the same day in each month as the Policy Date and is the date on which certain policy charges are deducted from the Accumulated Value. The first Monthly Payment Date is the Policy Date.

Net Accumulated Value – is the Accumulated Value less any Policy Debt.

Net Amount at Risk – is the difference between the Death Benefit and the Accumulated Value.

Net Premium – is the premium we receive for Life Coverage.

Owner, you, or your – refers to the Owner of this policy.

Policy Date – is shown in the Policy Specifications and means the date the policy and associated riders become effective. Policy and rider months, quarters, years and anniversaries are measured from this date.

Policy Debt – is the sum of the Loan Account and accrued Loan Interest charged.

Policy Specifications – is a section of the policy that shows information specific to your policy.

Risk Class – is used in determining policy charges and is determined by us during the underwriting process. Risk Class depends on the Insured's gender, health, tobacco use, and other factors. The Risk Class of the Insured is shown in the Policy Specifications. Risk Class may also be referred to as Risk Classification.

We, our, ours, and us – refers to Pacific Life Insurance Company.

Written Request – is your signed request in writing, or on a form we provide, and received by us at our Administrative Office, containing information we need to act on the request.

DEATH BENEFIT

When the Policy is In Force – This policy is In Force as of the Policy Date, subject to your acceptance of the delivered policy and payment of the initial premium. The policy remains In Force until the earliest of the following:

- Surrender, as described in the Surrender and Withdrawal of Values section;
- Lapse, as described in the Policy Lapse and Reinstatement section; or
- The death of the Insured.

Coverage under this policy will be reduced by any decreases in Face Amount, as described in later sections of this policy or riders attached to this policy.

Death Benefit – This policy provides a Death Benefit on the death of the Insured while this policy is In Force. This section describes how the Death Benefit is calculated. The Death Benefit is the larger of:

- The Face Amount reflecting any reductions as a result of withdrawals, any Terminal Illness Benefit Payment, or any rider benefits paid; or
- The Minimum Death Benefit according to the Cash Value Accumulation Test.

The Death Benefit as calculated above is subject to any increase required by the minimum death benefit provisions set out in General Provisions to satisfy certain federal tax qualification requirements.

Death Benefit Qualification Test – In order for your policy to qualify as a life insurance contract under the Code, it must at all relevant times satisfy the Cash Value Accumulation Test. The policy provides a Minimum Death Benefit amount, as needed, for the policy to qualify under the Cash Value Accumulation Test.

Minimum Death Benefit – The Minimum Death Benefit at any time will be the minimum amount required for this policy to qualify as a life insurance contract under the Code, but not less than 101% of the greater of the Accumulated Value or the Life Return of Premium Benefit.

Death Proceeds – The Death Proceeds ("Proceeds") amount is the actual amount payable to the beneficiary if the Insured dies while this policy is In Force. The Proceeds amount is equal to the greater of the Death Benefit or the Residual Death Benefit, as of the date of death:

- Less any Policy Debt; and
- Less any Monthly Deductions that may be due and unpaid if death occurs during a Grace Period.

Proceeds paid are subject to the conditions and adjustments defined in other policy provisions, such as General Provisions, withdrawals, Policy Loans, and Timing of Payments. We will pay interest on the Proceeds from the date of death at a rate not less than the rate payable for funds left on deposit (see the Income Benefits section). If payment of Proceeds is delayed more than 31 calendar days after we

receive the following requirements needed to pay the claim, we will pay additional interest at a rate of 10% annually beginning with the 31st calendar day referenced above. Proceeds are paid as a lump sum unless you choose to have the Proceeds paid under an income benefit plan available on the date of election, subject to our requirements.

We will pay the Proceeds to the beneficiary after we receive, at our Administrative Office:

- Due proof of the Insured's death, consisting of a certified copy of the death certificate for the Insured or other lawful evidence providing equivalent information;
- Proof of the claimant's legal interest in the Proceeds; and
- Sufficient evidence that any legal impediments to payment of Proceeds that depend on parties other than us have been resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; (c) submission of information required to satisfy state and federal reporting requirements; and (d) conflicting claims.

Residual Death Benefit – This policy provides a Residual Death Benefit if greater than the Death Benefit, in an amount equal to the lesser of 5% of the initial Face Amount, as shown on the Policy Specifications, or $5,000.00. Any withdrawals and any Terminal Illness Benefit Payment will reduce the Residual Death Benefit in the same proportion that they reduce the Face Amount.

Face Amount Changes – A requested increase or decrease in Face Amount is not allowed.

Face Amount Decreases – A decrease in Face Amount will occur as a result of:

- Withdrawals of policy Accumulated Value; or
- Rider benefits or Terminal Illness Benefit exercised while the policy is In Force.

The effective date of the decreased Face Amount will be the date we have processed the withdrawal, rider benefit, or Terminal Illness Benefit. Upon processing any decrease, we will send you written notification reflecting the decrease.

Change in Benefits – Under the Cash Value Accumulation Test, any change in policy or rider benefits or certain other factors may require an adjustment to the policy's tax qualification limits.

PREMIUMS

Premiums – The initial premium is payable either at our Administrative Office or to our authorized representative before we can place your policy In Force. At your request, we will give you a premium receipt signed by one of our officers. Additional premiums are optional and are payable at any time at our Administrative Office. We will consider any premium paid after the initial premium, whether delivered to an independent producer or otherwise, to be "received" when it is actually delivered to our Administrative Office. Except for the initial premium, we bear no responsibility for any premium unless we have received the premium. We reserve the right to reject premium payments less than $50 unless such premium is required to keep the policy In Force. Premiums may be paid at any time before the Monthly Deduction End Date, subject to the premium limits below. Any payment we receive from you while you have a loan will be first considered a loan repayment, unless you tell us by Written Request it is a premium payment.

Premium Processing – When a premium is received by us, the Net Premium will be credited to the Accumulated Value.

Premium Limitation – We reserve the right to require Evidence of Insurability satisfactory to us for any premium payment that would result in an increase in the Net Amount at Risk and, if such Evidence of Insurability is not satisfactory, to limit or refuse the premium payment, unless it is necessary to keep the policy In Force.

Modified Endowment Contract Premium Limit – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract under Section 7702A of the Code as of the Policy Date. Otherwise, in order that this policy not be classified as a Modified Endowment Contract under Section 7702A of the Code, the sum of premiums paid less a portion of any withdrawals may not exceed the 7-Pay limit as defined in the Code. The 7-Pay limit is the cumulative sum of the 7-Pay Premiums during the applicable 7-Pay testing period. In the event that a premium payment would cause the 7-Pay limit to be exceeded, we will refund the excess payment to you, unless you have provided a Written Request in which you accept your policy being classified as a Modified Endowment Contract and indicate that we may accept such payments and apply them to the policy, in accordance with the Modified Endowment Contract Tax Status subsection of this policy.

The 7-Pay Premium may change whenever there is a change in the Face Amount of insurance or in other policy benefits or factors. The 7-Pay Premiums are determined according to the rules applicable to this policy set forth in the Code. The 7-Pay Premium will be adjusted to conform to any changes in the Code. To the extent that a premium payment would cause such limits to be exceeded, we will refund the excess payment to you, in accordance with the Modified Endowment Contract Tax Status section of this policy. Further, as indicated in that section, we will increase the Death Benefit to the extent we deem necessary to continue to classify this policy as a non-Modified Endowment Contract under the Code.

TERMINAL ILLNESS BENEFIT

Terminal Illness Benefit – If the Insured has been diagnosed with a terminal illness, you have the option to receive a portion of the Face Amount while the Insured is still living. This is called a Terminal Illness Benefit. A "terminal illness" means an illness causing the Insured to have a life expectancy of 12 months or less.

Eligible Coverage – is the portion of the Face Amount that will qualify for determining the Terminal Illness Benefit at the time the benefit is exercised. Eligible Coverage is the policy Face Amount less any reductions as a result of withdrawals or paid rider benefits on the policy.

Requested Portion – is the amount of the Face Amount you request in a Written Request on a form provided by us. The Requested Portion cannot exceed the lesser of 75% of the Eligible Coverage or $500,000.

Requested Percentage – is the Requested Portion divided by the Eligible Coverage.

Terminal Illness Benefit Payment – is the actual dollar amount of benefit you will receive as a Terminal Illness Benefit. The Terminal Illness Benefit Payment will be determined as of the date we approve your Written Request for a Terminal Illness Benefit. Your Terminal Illness Benefit Payment will equal your Requested Portion less the following adjustments:

a) A reduction rate will be applied to the Requested Portion, and reflects the early payment of the Requested Portion of your policy. The reduction rate will be based on the12 month life expectancy of the ~~insured~~Insured at an annual interest rate declared by us. The reduction rate shall be no greater than the greater of the following rates in effect on the date of your written request for a Terminal Illness Benefit:
   i) the yield on 90-day treasury bills; or
   ii) the maximum statutory adjustable policy loan interest rate.

b) If there is a Policy Loan on your policy as of the date we approve your Written Request, we will reduce the Requested Portion in order to repay a portion of the Policy Loan equal to the Requested Percentage times the outstanding loan.

c) A processing charge deducted from the Terminal Illness Benefit, not to exceed $150.

We will refund the amounts discussed in a) and c) above should the death of the Insured occur within 30 days of the Terminal Illness Benefit Payment.

The Terminal Illness Benefit Payment will be paid as a lump sum. The minimum Terminal Illness Benefit Payment amount is $500. We place no restrictions on how you use any Terminal Illness Benefit that may be paid under this provision. ~~We will pay the Terminal Illness Benefit amount only once per Insured, even if such person may be insured under more than one policy with us.~~

This Terminal Illness Benefit is not meant to cause involuntary access to proceeds payable to the beneficiary on the death of the Insured. Therefore, this benefit is not available if either you or the Insured:

a) is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or

b) is required by a government agency to use this benefit in order to apply for, obtain or keep a government benefit or entitlement.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner or the Owner's estate while the Insured is still living, unless otherwise assigned or designated by the Owner, subject to any required acknowledgment of concurrence for payout. We will be discharged to the extent of any such payment made in good faith.

Effect of Terminal Illness Benefit Payment on Policy and Riders – After a Terminal Illness Benefit Payment is made, the policy and riders will remain In Force subject to the following adjustments. The Face Amount, Coverage Charge, and any Accumulated Value will be reduced by the Requested Percentage. The Return of Premium Benefit will be reduced by the Requested Portion corresponding to the Terminal Illness Benefit Payment amount paid. Any outstanding Policy Loan balance will be reduced as specified in the Terminal Illness Benefit Payment Section. Cost of Insurance Charges will be adjusted to reflect the reduction in the Death Benefit. A statement demonstrating how the Terminal Illness Benefit impacts your policy values will be sent with the Terminal Illness Benefit Payment.

Eligibility – The following conditions must be met before any Terminal Illness Benefit Payment is made:

- The policy must be In Force on the date the Terminal Illness Benefit Payment is approved;
- We must receive written proof that the life expectancy of the Insured is 12 months or less from the date of the Written Request. Proof will include the certification by a licensed physician. Such person may not be you or a member of your family. Such proof should include clinical, radiological or laboratory evidence of the condition. We reserve the right to obtain a second medical opinion from a physician of our choice at our expense. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion, at our expense, that is provided by a physician that is acceptable to you and to us.
- The ~~owner~~Owner or legal guardian must make the Written Request.

The Terminal Illness Benefit Payment will be paid immediately upon receipt of the due written proof of eligibility.

- **Terminal Illness Benefit Payment Notice –** Prior to or concurrent with the election to effect the Terminal Illness Benefit Payment, we will send the Owner, a statement demonstrating the effect of the Terminal Illness Benefit Payment on the Accumulated Value, Death Benefit, Premium, Cost of Insurance Charges, and Policy Loans (including loans to pay premiums).

Expiration Date – Your right to exercise the Terminal Illness Benefit will end when the policy is no longer In Force, when the Accumulated Value is zero, or when a Terminal Illness Benefit is paid.

Disclosure – The following should be taken into consideration before you exercise your option to receive the Terminal Illness Benefit:

- Policy Death Benefits, Coverage Charge, Accumulated Value, and Cash Surrender Value will be reduced if a Terminal Illness Benefit is paid;
- This Terminal Illness Benefit is NOT health, nursing home or long-term care insurance, and it is not intended or designed to eliminate the need for such coverage;
- Receipt of the Terminal Illness Benefit Payment may affect Medicaid, Medicare, and/or Supplemental Security Income (SSI) eligibility. Exercising the option to accelerate and receive benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility.

ACCUMULATED VALUE

Accumulated Value – The Accumulated Value equals the sum of:

- Fixed Accumulated Value; and
- Loan Account Value, as described in the Policy Loans section.

Fixed Accumulated Value – On the Policy Date, the Fixed Accumulated Value equals the Net Premium received less the first Monthly Deduction. On each other day, the Fixed Accumulated Value equals:

- The Fixed Accumulated Value as of the prior day;
- Plus interest earned on such amount since the prior day;
- Plus the amount of any Net Premiums received since the prior day;
- Less the amount of any withdrawal since the prior day;
- Less the amount of any Policy Loan, including any Policy Loan to pay Policy Loan interest, taken since the prior day;
- Less reduction for benefits paid since the prior day as described in the riders attached to this policy;
- Less reduction for the Requested Portion for any Terminal Illness Benefit Payment since the prior day as described in the Terminal Illness Benefit section;
- Plus the amount of any loan repayment made since the prior day; and
- Less, on a Monthly Payment Date, the Monthly Deduction.

We credit interest to the Fixed Accumulated Value on a daily basis at the end of each day, using a 365-day year, at a rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. At our discretion, we may credit additional interest. Any such additional interest may be adjusted to reflect expenses, taxes, profit, or sources of earnings other than investment earnings and will be applied uniformly to all members of the same Class. Once credited, the additional interest is nonforfeitable except indirectly due to the Surrender Charge.

POLICY CHARGES

Monthly Deduction – The Monthly Deduction provides coverage for the policy month following the Monthly Payment Date and is deducted from the Accumulated Value on each such date before the Monthly Deduction End Date. It is equal to the sum of the following items:

- The Cost of Insurance Charge;
- The Coverage Charge; and
- Rider charges, if any.

The maximum for each such charge is described below or in the rider forms. We may charge less than such maximum charge. Any lesser charge will apply uniformly to all members of the same Class.

Coverage Charge – This charge is based on the Face Amount of the policy and will not exceed the Maximum Monthly Coverage Charge shown in the Policy Specifications. The Coverage Charge will decrease proportionately to the Face Amount Decrease as a result of a withdrawal or payment of a Terminal Illness or rider benefit.

Rider Charges – Any rider charges are described in the rider.

Cost of Insurance Charge – The Cost of Insurance Charge is equal to (1) multiplied by (2), where:
(1) is the Monthly Cost of Insurance Rate divided by 1000 as shown in the Policy Specifications; and
(2) is the Death Benefit divided by the Net Amount at Risk Factor shown in the Policy Specifications, reduced by the Accumulated Value as of the beginning of the policy month before the Monthly Deduction is assessed.

Cost of Insurance Rates – The Maximum Monthly Cost of Insurance Rates for the initial Life Coverage are shown in the Policy Specifications.

POLICY LAPSE AND REINSTATEMENT

Grace Period – If the Accumulated Value less Policy Debt on a Monthly Payment Date is sufficient to cover the Monthly Deduction due, the policy will continue In Force. If the Accumulated Value less Policy Debt on a Monthly Payment Date is not sufficient to cover the Monthly Deduction due, a Grace Period of 61 days will be allowed for the payment of sufficient loan repayment or premium to keep your policy In Force. The Grace Period begins on the Monthly Payment Date on which the insufficiency occurred and ends 61 days thereafter. At the start of the Grace Period, we will provide a Grace Notice to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. There is no penalty for paying a premium during the Grace Period. Your policy will remain In Force during the Grace Period.

Notification of Termination for Non-Payment – Thirty days after the Monthly Payment Date on which the insufficiency occurred, we will provide a notification of termination for non-payment to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. The notice will be provided to each person at their last known addresses by first class United States mail, postage prepaid and will state the due date and the amount of loan repayment or premium required for your policy to remain In Force. A minimum of the monthly charges not deducted plus three times the monthly deduction due when the insufficiency occurred must be paid.

Lapse – If sufficient loan repayment or premium is not paid by the end of the Grace Period, a lapse will occur. If the Insured dies during the Grace Period, the Death Proceeds will be equal to the Death Proceeds as of the beginning of the Grace Period reduced by any overdue charges. Upon lapse, the policy will terminate with no value.

Reinstatement – If it has not been surrendered, this policy may be reinstated within five years after the end of the Grace Period. To reinstate this policy you must provide us with the following:

- A written application;
- Full repayment of Policy Debt, if a loan was outstanding at the time of lapse;
- Evidence of Insurability satisfactory to us; and
- Sufficient premium to cover all Monthly Deductions and Loan Interest Charges due and unpaid during the Grace Period.

The effective date of the policy reinstatement will be the Monthly Payment Date on or next following the date we approve your reinstatement application. Upon reinstatement:

- The Accumulated Value will equal the amount it was at the beginning of the Grace Period, plus the reinstatement Net Premium, less Monthly Deductions as indicated below (including those due and unpaid during the Grace Period);
- The Surrender Charges and policy charges (other than Cost of Insurance Charges) for Life Coverage under this policy will resume on their schedule as of the Monthly Payment Date when lapse occurred;
- Cost of Insurance Charges will be calculated using Cost of Insurance Rates that resume their original schedule as if lapse had never occurred, reflecting the Insured's Age at reinstatement and policy duration measured from the original Policy Date; and
- The periods during which we may exclude death by suicide and contest coverage due to a material misstatement in the reinstatement application will begin from the reinstatement date.

After the reinstatement premium has been applied, regular policy processing of Monthly Deductions will occur for the period of time when coverage was provided during the Grace Period. There will be no Monthly Deductions between the time of lapse and reinstatement.

SURRENDER AND WITHDRAWAL OF VALUES

Surrender – Upon Written Request while the policy is In Force, you may surrender this policy for its Net Cash Surrender Value. If surrendered within 30 days following a policy anniversary, the value available shall not be less than the anniversary value, less any withdrawal, Policy Loan, Terminal Illness Benefit Payment, or rider benefit paid since the policy anniversary. If surrendered at any time other than on a policy anniversary, the value available shall be calculated with allowance for lapse of time from the last preceding policy anniversary. The policy will terminate on the date the Written Request is received at our Administrative Office. The policy cannot be surrendered during the Grace Period.

Net Cash Surrender Value – The Net Cash Surrender Value is the Cash Surrender Value less any Policy Debt.

Life Return of Premium Benefit – The Life Return of Premium Benefit is equal to the Life Coverage Premium Amount at issue, as shown in the Policy Specifications.

Return of Premium Benefit – The Return of Premium Benefit is not available if your policy was issued upon the exercise of a conversion option from another policy. Otherwise, the Return of Premium Benefit, if greater than the Accumulation Value less any Surrender Charge, is available upon surrender of the policy. The Return of Premium Benefit is equal to the sum of the Life Return of Premium Benefit and any Return of Premium Benefit under riders attached to the policy. There are no increases to the Return of Premium Benefit after issue, even if additional premiums are paid.

After issue, the Return of Premium Benefit is reduced by the following events:
- Any withdrawals;
- The Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy; and
- Any benefit payments made under the riders.

These events will reduce the Life Return of Premium Benefit first (but not below zero), and then any Return of Premium Benefit under riders attached to the policy.

Cash Surrender Value – The Cash Surrender Value is equal to the greater of:
- The Accumulated Value less any Surrender Charge; or
- The Return of Premium Benefit.

Surrender Charge – If you surrender this policy, there may be a Surrender Charge deducted from the Accumulated Value. During the Level Period, the Surrender Charge is equal to the Initial Amount. After the Level Period, the Surrender Charge decreases by the Reduction Factor for the remaining Surrender

Charge Period. The Initial Amount, Level Period, Reduction Factor and Surrender Charge Period are shown in the Policy Specifications.

Withdrawals – Upon Written Request on or after the first policy anniversary, you may withdraw a portion of the Net Cash Surrender Value of this policy. Such withdrawal will be deducted from the Accumulated Value. There is no Surrender Charge imposed for a withdrawal, even if the Face Amount is reduced as a result of the withdrawal. Withdrawals may be restricted or prohibited by certain riders attached to the policy. Withdrawals will be subject to the following conditions:

- The amount of each withdrawal must be at least $200;
- The Net Accumulated Value less any Surrender Charge remaining after a withdrawal must be at least $500; and
- The Face Amount remaining after the withdrawal must be at least $50,000.

A withdrawal will reduce the Face Amount in proportion to the amount of the withdrawal divided by the Accumulation Value before the withdrawal. If such a reduction in Face Amount would cause the policy to become a Modified Endowment Contract, we will not process your withdrawal request unless and until we receive your Written Request to have your policy classified as a Modified Endowment Contract. Refer to the Premiums section for details.

If the Insured dies after the request for a withdrawal is received by us and prior to the withdrawal being processed, the withdrawal, if allowed under this provision, will be processed and paid to the ~~owner~~Owner, or to the ~~owner's~~Owner's estate, before the Death Proceeds are determined and paid to the beneficiary.

INCOME BENEFITS

Income Benefits – All or part of any policy proceeds may, instead of being paid in a lump sum, be left with us under any one, or a combination of the income benefit plans available, subject to our minimum amount requirements on the date of election. If the payee is not a natural person, the choice of a payment option will be subject to our approval. We guarantee that the income benefit will not be less than the income that would be provided by the immediate annuity purchase rates we offer at the time. We guarantee that we will have at least the following income benefit plans available.

Fixed Income – Equal payments of the amount chosen with interest of not less than 2% per year until the funds left on deposit are exhausted.

Life Income – Monthly income will automatically be guaranteed to continue for at least ten years. If the payee dies before the end of the ten-year period, payments will continue to the end of the ten-year period to a person designated in writing by that payee. The purchase rates for the monthly income for a male or female income recipient bought by each $1,000 of benefits are shown below.

Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income
0-30	2.38	40	2.63	50	3.00	60	3.60	70	4.63
32	2.42	42	2.69	52	3.10	62	3.76	72	4.92
34	2.47	44	2.76	54	3.20	64	3.94	74	5.26
36	2.52	46	2.83	56	3.32	66	4.14	75+	5.45
38	2.57	48	2.91	58	3.45	68	4.37		

Monthly income amounts for ages not shown are halfway between the two amounts for the nearest two ages that are shown. Amounts shown are based on an annual interest rate of 2% and the Annuity 2000 female mortality table with five-year age setback. We may require evidence of survival for incomes that last more than ten years.

POLICY LOANS

Policy Loans – You may obtain policy loans by Written Request after the Free Look Period, on the sole security of the Loan Account of this policy. We recommend you consult your tax advisor before requesting a policy loan.

Loan Amount Available – The amount of the loan must be at least $200. The maximum amount available for a loan on any date is equal to the Accumulated Value less:

- Three times the most recent Monthly Deduction;
- Any Surrender Charge; and
- Any existing Policy Debt.

Loan Account – The amount of any Policy Loan will be added to the Loan Account.

Loan Repayment – You may make loan repayments at any time prior to lapse of this policy. Any payment we receive from you while you have a loan will be treated as a loan repayment, unless you tell us by Written Request that it is a premium payment.

Loan Interest Charge – Interest will accrue daily based on the balance in the Loan Account and will be due on each policy anniversary. Such interest is calculated using the simple interest method and is based on the balance in the Loan Account, using an annual interest rate of 5.50%. The corresponding daily interest rate is equal to the annual rate divided by 365. If the policy terminates before a policy anniversary, the Loan Interest Charge will be due at such time.

Policy Debt – The Policy Debt is the amount necessary to repay the Policy Loan in full and is equal to the Loan Account plus any Loan Interest Charge. The Policy Debt reduces any amount otherwise payable under the policy.

Loan Account Value – The Loan Account Value is a portion of the Accumulated Value set aside to secure the Policy Debt. The Loan Account Value is equal to the Loan Account plus Loan Interest. Such interest is based on the balance in the Loan Account, and accrues daily on a simple interest basis, using the Loan Account Interest rate, which is an annual interest rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. The corresponding daily interest rate is equal to the annual rate divided by 365.

Loan Processing on Policy Anniversary – On each policy anniversary we will adjust the values of the Policy Debt, Loan Account and Loan Account Value so that they are equal to each other. To do this, we calculate the difference between the Policy Debt and the Loan Account Value. If the Policy Debt is greater than the Loan Account Value, which is generally the case when the policy loan interest has not been paid, a new loan will be taken for the excess and will be added to the Loan Account. If the Loan Account Value is greater than the Policy Debt, which is generally the case when the policy loan interest has been paid, the excess will be transferred into the Fixed Accumulated Value.

OWNER AND BENEFICIARY

Owner – The Owner of this policy is as shown in the Policy Specifications or as later changed by Written Request. If you change the Owner, the change is effective on the date the Written Request is signed, unless otherwise specified by the Owner, subject to our receipt of it and subject to any action taken or payment made by us prior to its receipt. If there are two or more Owners, they will own this contract as joint tenants with right of survivorship, unless otherwise provided by Written Request. We recommend you consult your tax advisor before requesting a change of Owner.

Assignment – You may assign this policy by Written Request. An assignment must be recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed, unless otherwise specified by the Owner. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be

responsible for the validity of any assignment. We recommend you consult your tax advisor before requesting an assignment.

Beneficiary – The beneficiary is named by you in the Application to receive the Death Proceeds. You may name one or more beneficiaries. If you name more than one beneficiary, they will share the Death Proceeds equally or as you may otherwise specify by Written Request. If you have named a contingent beneficiary, that person becomes the beneficiary if the beneficiary dies before the Insured. A beneficiary may not, on or after the Insured's death, assign, transfer or encumber any benefit payable. To the extent allowed by law, policy benefits will not be subject to the claims of any creditor of any beneficiary.

You may make a change of beneficiary by Written Request on a form provided by us while the policy is In Force. The change will take place as of the date the request is signed~~.~~, unless otherwise specified by the Owner. Any rights created by the change will be subject to any payments made or actions taken by us before we have received the Written Request.

The interest of a beneficiary who does not outlive the Insured will be divided pro rata among the surviving beneficiaries. If no beneficiaries survive to receive payment, the death proceeds will pass to the Owner, or the Owner's estate if the Owner does not survive the Insured. In the event of a simultaneous death of the Insured and a beneficiary such that it cannot be determined who died first, it will be assumed, unless proof to the contrary is provided, that the beneficiary died last.

GENERAL PROVISIONS

Entire Contract – This policy is a contract between you and us. This policy, the attached copy of the initial Application, including any amendments and endorsements to the Application, any applications for reinstatement, any endorsements, benefits, or riders, and all additional policy information sections added to this policy are the entire contract. Only our president, chief executive officer or secretary is authorized to change this contract or extend the time for paying premiums. Any such change must be in writing.

All statements in the Application shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or defend a claim on grounds of misrepresentation unless the statement is in an Application.

Incontestability – We will not contest this policy unless there was a material misrepresentation in the Application. We will rescind the policy if:

- The policy has been In Force for less than six months and we determine that the Application contains a misrepresentation that is material to acceptance for coverage; and
- The policy has been In Force for at least six months but less than two years and we determine that the Application contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy, we will return to you the premiums paid less any policy loans, any withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. No Death Benefit will be paid. This policy cannot be contested, except as provided below, after it has been In Force for two years during the Insured's lifetime.

If this policy lapses and is later reinstated, we will rescind the policy as of the reinstatement date if:

- Less than six months after the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the reinstatement date but less than two years from the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy following reinstatement, we will return to you the premiums paid after the reinstatement date less any policy loans and any withdrawals taken after the reinstatement date. No Death Benefit will be paid. We will not contest the reinstated policy after it has been In Force for two years following such reinstatement during the Insured's lifetime.

If there has been a change to the policy for which we required the Insured to submit Evidence of Insurability, we will rescind the policy change and all policy charges made after the change will be reversed and corrected charges applied so that the policy's Accumulated Value will be unaffected by the change if:

- Less than six months after the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the change but less than two years from the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

Any Death Benefits or other benefits that become payable will be determined as though the policy change had never been requested. We will not contest any such change after two years following the effective date of the change during the Insured's lifetime.

Non-Participating – This policy will not share in any of our surplus earnings.

Suicide Exclusion – If the Insured dies by suicide, while sane or insane, within two years of the Policy Date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid, less the sum of any policy loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. ~~If this policy has been reinstated and the Insured dies by suicide, while sane or insane, within two years of the latest reinstatement date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid less the sum of any policy loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy since such date.~~

Misstatement – If the Insured's sex or birth date is misstated in the Application and it is discovered on or after the death of the Insured, the Death Benefit shall be the minimum Death Benefit for the correct sex and birth date, or if greater, a Death Benefit based on a Net Amount at Risk adjusted by the ratio of the incorrect Cost of Insurance Rate to the correct Cost of Insurance Rate. The adjusted Net Amount at Risk will result in an adjusted Death Benefit, since the Death Benefit depends on the Net Amount at Risk.

If the Insured's sex or birth date is misstated in the Application and it is discovered before the death of the Insured, we will not recalculate the Accumulated Value using the correct sex and birth date of the Insured.

Maturity – This policy does not mature, but will continue In Force so long as the Insured is alive and the policy has not been surrendered and lapse has not occurred.

After the Monthly Deduction End Date – Provided the policy is still In Force, coverage will continue on and after the Monthly Deduction End Date, subject to all policy provisions, with these exceptions and clarifications:

- Monthly Deductions will cease;
- Premiums will not be accepted, except amounts required to keep the policy in force;
- Loans will be allowed;
- Loan repayments will be permitted;
- Loan interest will continue to accrue; and
- Withdrawals will not be allowed.

Timing of Payments – We may defer payments of any Net Cash Surrender Value, withdrawal or loan (except for loans to pay a premium on any policy issued by us) for up to six months after we receive your request. If we defer any such payment for more than 30 days after we receive your request, we will pay

interest at ~~the rate required by the state in which this policy is delivered, and such rate will be at~~ least equal to the Guaranteed Annual Interest Rate shown in the Policy Specifications.

Annual Report – A report will be mailed to your last known address no less frequently than annually. This report will show:

- The beginning and end dates of the reporting period;
- The Accumulated Value at the beginning and end of the reporting period;
- Amounts that have been credited or debited to the Accumulated Value during the reporting period, identified by type;
- The Death Benefit at the end of the reporting period;
- The Net Cash Surrender Value at the end of the reporting period;
- A notice if the Net Cash Surrender Value will not be sufficient to keep the policy in force until the end of the next reporting period, unless further premium payments are made;
- Any Policy Debt outstanding at the end of the reporting period; and
- Any other information required by law.

Additional Report – Each year, you may request, without charge, an additional report showing the same information as the Annual Report.

Basis of Values – All nonforfeiture values for this policy will be at least equal to the minimums required by the state in which this policy was delivered. Cash Values and nonforfeiture benefits available under this policy are not less than the minimum values and benefits required by or pursuant to the law of the state where the policy was delivered. To calculate the minimum required nonforfeiture values, we use the Guaranteed Annual Interest Rate shown in the Policy Specifications and mortality rates from the 2001 CSO mortality tables using age last birthday. The rates we use are both smoker and sex distinct.

Tax Qualification as Life Insurance – This policy is intended to qualify as a life insurance contract for federal tax purposes, and the Death Benefit under this policy is intended to qualify for federal income tax exclusion. The policy, including any rider, benefit or endorsement that does not specifically override this tax qualification provision, shall be interpreted to ensure and maintain such tax qualification, despite any other provision to the contrary. At no time shall the amount of Death Benefit under this policy ever be less than the minimum amount needed to ensure or maintain such tax qualification. If need be, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary to accomplish that purpose. In addition, the Accumulated Value will be reduced to reflect the increased Monthly Deductions that result from such Death Benefit increase(s), starting on the date that each increase is effective. **As of the effective date of the filing of this policy in the state in which it was delivered, the Internal Revenue Service has not published final guidance on all aspects of the tax treatment of life insurance policies that continue coverage beyond Age 100. You should consult your tax advisor, as there may be tax consequences**.

If you request a withdrawal that causes a decrease in policy or rider benefits, it may cause a reduction in any applicable tax limits on premiums or Accumulated Value for the policy to maintain such tax qualification. Such a reduction in these limits may require us to make a distribution from the policy equal to the greatest amount by which the premiums paid or Accumulated Value for the policy exceed any such reduced limits, as determined under federal tax law, in order to maintain the policy's tax qualification. If such a distribution is made, the distribution will be paid to you and the Accumulated Value will be reduced by the amount of the distribution. However, no request for a withdrawal that causes a decrease in policy or rider benefits will be allowed to the extent that we determine that the resulting reduction in such tax limits would require us to distribute more than the Net Cash Surrender Value for the policy.

Modified Endowment Contract Tax Status – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract ("MEC") as of the Policy Date. If, at the time your policy is issued, we have classified it as a MEC, this will be indicated on the Policy Specifications. Otherwise, unless and until you have given us a Written Request to accept a MEC classification for your policy, the provisions of this Modified Endowment Contract Tax Status subsection apply to your policy.

Under federal tax law, if the funding of a life insurance contract occurs too rapidly, it becomes a MEC and fails to qualify for certain favorable tax treatment as a result. This policy is intended to qualify as a life insurance contract that is not a MEC for federal tax purposes. To achieve these purposes, the provisions

of this policy (including any rider or endorsement that does not specifically override this tax qualification provision) shall be interpreted to prevent this policy from being subject to such MEC treatment, despite any other provision to the contrary. If and while the provisions of this subsection apply to your policy, the amount of Death Benefit under this policy shall never be less than the minimum amount needed to avoid such MEC treatment.

We will not accept a payment as premium or otherwise which would cause the policy to become a MEC. The 7-Pay Premium, shown on Page 3.0, is used solely to determine the policy's premium limits to avoid MEC treatment. Payment of one or more 7-Pay Premium amounts does not guarantee that the policy will never lapse, and additional premiums may be necessary to prevent the policy from lapsing in the future.

If at any time the amounts paid under the policy exceed the limit for avoiding such MEC treatment, this excess amount, including any interest as determined under federal tax law, shall be removed from the policy as of the date of its payment, and any appropriate adjustment in the Death Benefit and/or Accumulated Value shall be made as of such date. This excess amount, including any interest, shall be refunded no later than 60 days after the end of the applicable contract year, as determined under federal tax law.

If this excess amount is not refunded by the end of such 60-day period, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary (e.g., to the end of any MEC 7-year test period) so that at no time is the Death Benefit ever less than the minimum amount necessary to avoid Modified Endowment Contract classification. In addition, the Accumulated Value will be reduced to reflect any increased Monthly Deductions resulting from such Death Benefit increase, starting on the date that the increase is effective.

Any request that would change the Death Benefit or any other benefit or rider under the policy will not be processed if the change would cause the policy to be classified as a Modified Endowment Contract. Requested changes that could cause the policy to be classified as a Modified Endowment Contract include, but are not limited to a withdrawal that would cause a reduction in the Face Amount.

Other Distributions of Accumulated Value – If the Net Amount at Risk ever exceeds three times the original Face Amount, we reserve the right to make a distribution of Accumulated Value to make the Net Amount at Risk equal three times the original Face Amount. In such case, the distribution will be treated as a premium refund. Note that while such a distribution will be treated as a premium refund for certain contract purposes, normal tax rules will apply in determining the amount of such a distribution, if any, which is taxable.

Additional Services – While this policy is In Force, we may, either directly or through a third party service provider, provide you with access to independent living-related resources and discounted independent living-related goods and services.

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PACIFIC LIFE

Pacific Life Insurance Company, 45 Enterprise, Aliso Viejo, CA 92656

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Proceeds Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**
- **Terminal Illness Benefit (Accelerated Death Benefit)**

P11PPC

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

STATEMENT OF GOOD HEALTH AND INSURABILITY

Proposed Insured's Name: First MI Last	Policy Number

~~I certify to Pacific Life Insurance Company (PLIC), to the best of my knowledge and belief, since the date of my [Pacific PremierCare] telephone interview:~~

1. ~~There has been no change in my health.~~
2. ~~I am able to perform all activities of daily living without assistance (eating, toileting, transferring, bathing, dressing, and continence).~~
3. ~~The information on my application is correct and there have been no changes to any of my answers to the questions on my application.~~
4. ~~I have had no illness or injury, have not been seen or treated by any physician or health care provider except for those identified on my application, and have not been hospitalized.~~
5. ~~I have not been declined, rated, or postponed for long-term care insurance.~~

~~If any of the above statements are not accurate, provide full details, including dates in the Remarks Section below (or attach sheets, if necessary).~~

If your answer to any of the following questions is "Yes", provide full details and dates in Remarks (or attach sheets, if necessary).

Since the date of the [Pacific PremierCare] telephone interview:

	YES	NO
1. Has there been any change in your health?	☐	☐
2. Have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
3. Have there been any changes to any of the medical information questions on the application?	☐	☐
4. Have you been declined, rated, or postponed for long-term care insurance?	☐	☐

Caution: If your answers on the application or Statement of Good Health and Insurability are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

REMARKS

SIGNATURES

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

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE

X

Proposed Insured's Signature

SIGN HERE

X

Policyowner's Signature

SIGN HERE

X

Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

PACIFIC LIFE

[PACIFIC PREMIERCARE] TEMPORARY INSURANCE AGREEMENT (TIA)

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

This TIA provides a limited amount of life insurance coverage, for a limited period of time, subject to the Terms and Conditions shown below.

Payment in the amount of $ _____(checks must be made payable to "Pacific Life Insurance Company") is made in connection with this TIA on the life of the proposed insured named above.

Within the past 90 days, ~~has the Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended~~ have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been given medical advice by a member of the medical profession to have any hospitalization or surgery which has not been scheduled or completed? ☐ Yes ☐ No

If the above question is answered YES or LEFT BLANK, no representative of Pacific Life Insurance Company (PLIC) is authorized to accept money, and NO COVERAGE will take effect under this TIA.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $600,000 MAXIMUM	If money has been accepted by PLIC as payment in connection with this TIA and if the Proposed Insured dies while this TIA is in effect, PLIC will pay the designated beneficiary the amount of death benefits, if any, that would be payable under a requested [Pacific PremierCare] Policy if such were issued, which amount shall not exceed $600,000.
DATE COVERAGE BEGINS	Temporary life insurance under this TIA will begin on the date of this TIA, but only if a request for a [Pacific PremierCare] Policy has been initiated, and payment is received by PLIC on the same date or not more than 10 days prior to the date of this TIA.
DATE COVERAGE TERMINATES (45 DAY MAXIMUM)	Temporary life insurance under this TIA will terminate automatically on the earliest of: a. 30 days from date of this TIA if a required phone history interview is not completed and received by PLIC; or b. 45 days from the date of this TIA; or c. the date any [Pacific PremierCare] Policy is offered; or d. five days after the date PLIC mails notice of termination of coverage under this TIA and refunds the full amount of payment referenced above.
LIMITATIONS	• This TIA does not provide benefits for long term care coverage. • Fraud or material misrepresentation made in a request for a [Pacific PremierCare] Policy or any Application or in the answer to the above question in this TIA invalidates this TIA, and PLIC's liability shall be no greater than the refund of any premium payment made in connection with this TIA. • If the Proposed Insured dies by suicide, PLIC's liability under this TIA is limited to a refund of the payment made. • There is no coverage under this TIA if the check submitted as payment is not honored by the bank on first presentation. • If the Proposed Insured has more than one TIA in effect, the maximum aggregate coverage under any and all TIAs is $1,000,000. • **No one is authorized to waive or modify any of the provisions of this TIA.**

I HAVE RECEIVED A COPY OF AND HAVE READ THIS TIA AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL OF ITS TERMS AND CONDITIONS.

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

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE
X
Proposed Insured's Signature

SIGN HERE
X
Policyowner's Signature, if other than Proposed Insured include Title, if Corporation, Trust or Business Entity

SIGN HERE
X
Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy. All references to "you" on this form apply to the policyowner(s). (Complete one form per policyowner.)

PREMIUM INFORMATION

Policy and Rider Form Numbers: [P11PPC – Flexible Premium Adjustable Life Insurance Policy
R11ABR – Accelerated Benefit Rider
R11EBR – Extended Benefit Rider]

The premium for the coverage you are considering will be a one-time single premium of $_____.

Type of Policy: Non-Cancellable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

The company cannot raise your rates on this policy.

RATE INCREASE HISTORY

The company has sold long-term care insurance since 2012 and this policy form since [2012]. The company has never raised its rates for any long-term care policy it has sold.

SOURCE OF PREMIUM

How will you pay for this policy? (Check all that apply)

☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

QUESTIONS RELATED TO YOUR INCOME

What is your annual income? (Check one)

[☐ Under $10,000 ☐ $20,000 - $49,999 ☐ $100,000 - $149,999]

[☐ $10,000 - $19,999 ☐ $50,000 - $99,999 ☐ $150,000 and over]

How do you expect your income to change over the next 10 years?

☐ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Questions Related to Your Income (Continued)

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount? (Check all that apply) ☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

The national average annual cost of nursing home care in [2009] was [$72,270], but this figure varies across the country. In ten years the national average annual cost would be about [$117,800] if costs increase 5% annually. [(Source: National Long-Term Care Clearinghouse, 2009.)]

The elimination period for nursing home care under the rider is ~~30~~ [90] days. Based on the year [2009] figures provided above, this means approximately [$6,023] in nursing home costs will be incurred before benefits are payable.

How are you planning to pay for your care during the elimination period? (Check all that apply)
☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home and premium for this policy, about how much are all of your assets (your savings and investments) worth?

[☐ Under $20,000 ☐ $30,000 - $49,999 ☐ $100,000 - $249,999 ☐ $500,000 and over]

[☐ $20,000 - $29,999 ☐ $50,000 - $99,999 ☐ $250,000 - $499,999]

How do you expect your assets to change over the next ten years? (Check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statements

Check one:	☐ The answers to the questions above describe my financial situation. or ☐ I choose not to complete this information.

☐ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. (This box must be checked.)

Signatures

SIGN HERE X _____ Date (mm/dd/yyyy) _____

Policyowner's Signature

Policyowner's Name: First MI Last (print)

☐ I explained to the policyowner the importance of completing this information.

SIGN HERE X _____ Date (mm/dd/yyyy) _____

Producer's Signature

Policyowner's Name: First MI Last (print)

Sign below only if your producer has advised you that this policy may not be suitable for you.

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

SIGN HERE X _____ **Date** (mm/dd/yyyy) _____

Policyowner's Signature

The company may contact you to verify your answers.

Insured: [Jane Doe] Policy Number: [LTC9999990]

AVIATION EXCLUSION RIDER

Risks Not Covered – This policy does not cover death, disability, or chronic illness or any benefit that would be payable to a Chronically Ill Individual resulting from injuries sustained as a result of riding in, descent with or descent from an aircraft unless~~:~~ the deceased was a fare-paying passenger.

- ~~The deceased was a fare-paying passenger; and~~
- ~~The aircraft was being operated by a duly licensed passenger carrier on a regular schedule over its established route.~~

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The amount payable under this policy in the event of death as a result of a risk not covered will be the greater of:

- Total premiums received under this policy (without interest) less any withdrawal amounts, the Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy, and any benefit payments made under the policy riders; or
- An amount equal to the Cash Surrender Value of this policy.

Any existing Policy Debt on this policy will be deducted from the amount payable. However, the total amount payable will not exceed the payment that would have been made in the absence of this rider.

General Conditions – This rider is part of the policy to which it is attached. This rider becomes effective on the Policy Date unless otherwise specified.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

LTCX

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PACIFIC LIFE INSURANCE COMPANY
[45 Enterprise, Aliso Viejo, CA 92656
(800) 347-7787
www.PacificLife.com]

PACIFIC LIFE

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE

Rider Forms R11ABR and R11EBR

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

CAUTION: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application will be attached to any issued Policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy and Riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: [45 Enterprise, Aliso Viejo, CA 92656].

1. **THIS POLICY AND THE RIDERS PROVIDE INDIVIDUAL COVERAGE**
   The Policy is a flexible premium adjustable life insurance policy with individual long-term care insurance Riders. If the base life insurance Policy is issued, the Accelerated Benefit Rider (ABR) will also be issued. The coverage under the ABR provides two years of long-term care insurance benefits by accelerating payment of the life insurance policy's face amount. The Extended Benefit Rider (EBR) is an optional purchase and provides between one and six years of additional long-term care benefits, depending on the duration elected. You may elect to purchase the Policy and ABR without purchasing the EBR. This outline of coverage describes both the ABR and the EBR (Riders). Capitalized terms used in this outline of coverage are defined in the Definitions section, starting on page 8.

2. **PURPOSE OF THE OUTLINE OF COVERAGE**
   This outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Riders contain governing contractual provisions. This means that the Policy and Riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES**
   These Riders are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. **TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED**
   RENEWABILITY: THIS COVERAGE IS NONCANCELLABLE – This means you have the right, subject to the terms of your Policy and Riders, to continue your coverage as long as the single premium is paid. We cannot change any of the terms of your coverage on our own and cannot

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require that you pay additional premium after the Riders are issued, including for any Inflation Benefit Option.

Waiver of Premium – A waiver of premium provision waives premium payments that become due when an insured is receiving benefits under the coverage. There is no waiver of premium for these Riders because there is a single premium required and it must be paid prior to the coverage being issued. After issue there are no further premiums required that could be waived.

5. **TERMS UNDER WHICH WE MAY CHANGE PREMIUMS**
   We do not have the right to change the premium rates for your coverage. This coverage requires a single premium and it must be paid prior to the Policy and Riders being issued. After issue, you will not be required to make any additional premium payments.

6. **TERMS UNDER WHICH THE POLICY AND RIDERS MAY BE RETURNED AND PREMIUM REFUNDED**
   The Owner has 30 days from the day the Policy and Riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and the Riders. The Policy and Riders can be returned to us at our Administrative Office or to the Producer~~/Representative~~ through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid within 30 days of such a Policy and Rider return and the Policy and Riders will be void from the start.

   Return of Premium Benefit – The Riders each include a Return of Premium Benefit that is payable if the coverage is surrendered or lapsed. At issue, the Return of Premium Benefit is equal to the premium paid for the ABR or EBR, as shown on the Policy specifications. After issue, the Return of Premium Benefit may be reduced by withdrawals, a Terminal Illness Benefit Payment (available under the terms of the Policy) or benefit payments under the Riders, as described in the Riders.

   Limited Refund on Death – Some of the premium paid for the Riders may be refunded on the death of the Insured. The amount of refunded premium, if any, will be based on the premium paid for the Riders, adjusted for any death benefit payable under the Policy, benefit payments made under the Riders, Terminal Illness Benefit Payment or withdrawals, as described in the Riders.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**
   If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor our producers/representatives represent Medicare, the federal government, or any state government.

8. **LONG-TERM CARE COVERAGE**
   Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home facility, in the community, or in the home.

   With the exception of the International Benefit, which applies only to the ABR, this coverage provides reimbursement benefits. Reimbursement benefits reimburse the Owner for covered long-term care expenses incurred. The International Benefit under the ABR pays indemnity benefits. Indemnity benefits pay a fixed dollar amount regardless of the amount of expenses incurred. All benefits are subject to limitations, an Elimination Period and other requirements.

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9. BENEFITS PROVIDED BY THE COVERAGE

Benefits are available under the ABR up to the Monthly Maximum Benefit Amount until the Maximum ABR Benefit Limit is reached. The EBR extends most of the benefits provided by the ABR, subject to the Maximum Benefit Amount, until the Maximum EBR Benefit Limit is reached. The Non-Continual Alternative Care Benefit and the Caregiver Training Benefit are subject to lifetime maximums specific to those benefits. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits for the following Covered Expenses:

Care Coordination and Care Coordination Benefit – Care Coordination is intended to help identify an Insured's specific care needs and long-term care services and programs available to meet those needs. Care Coordination will provide the Insured with a Care Coordinator who will review the Insured's specific situation and develop Plans of Care to meet the Insured's needs. The Care Coordinator will: assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis; work with the Insured to determine the specific services the Insured requires; develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs; coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and help the Insured arrange for care.

Care Coordination provided by us does not require a claim for benefits and does not count against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Care Coordination not performed by us requires a claim for Care Coordination Benefits, which counts against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Benefits are payable for Covered Expenses the Insured incurs for Care Coordination not performed by us during the Policy month up to the Monthly Maximum Benefit Amount.

Nursing Home Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in a Nursing Home Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses also include Hospice Care provided by a Hospice Care Facility. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Nursing Home Benefit will be pro-rated.

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in an Assisted Living Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Assisted Living Facility Benefit will be pro-rated.

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care, which include the following services when provided by a

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Home Health Care Agency or by an Independent Provider: Home Health Care Services; Maintenance or Personal Care Services; Hospice Care; and Respite Care. Covered Expenses also include Adult Day Care provided by an Adult Day Care Center. Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Home and Community Care Benefit will be pro-rated.

International Benefit – The International Benefit is included as part of the ABR only and is not available under the EBR. The Insured is eligible to receive the full Monthly Maximum ABR Benefit Amount when Confined in a Nursing Home Facility outside the United States. No other benefit is payable under the ABR during any Policy month for which the Insured receives the International Benefit. This cash benefit will be available beginning on the date the Insured first satisfies the Eligibility for Payment of Benefits requirements and is Confined to a Nursing Home Facility outside the United States. The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and is Confined in a Nursing Home Facility outside the United States in order to receive this benefit. For proof of this, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. The Insured must provide written proof every 90 days, in English, that the Insured is a Chronically Ill Individual. The cost for providing any proof required for this benefit is the responsibility of the Owner. We must be notified in advance to receive the International Benefit and such notice must be made in writing and in English. Each month the Insured is eligible for the International Benefit, benefits are payable in the amount of the Monthly Maximum ABR Benefit Amount. If the Insured is not a Chronically Ill Individual each day of the Policy month, the International Benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

Alternative Care Benefit – We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the Riders. Benefits and services can be authorized if we determine that they: are cost-effective; are appropriate to the Insured's needs; are consistent with general standards of care; provide the Insured with an equal or greater quality of care; and are for and constitute Qualified Long-Term Care Services. Any benefits, treatments or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician. We reserve the right to decline to authorize benefits and services. Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits.

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment up to the Non-Continual Alternative Care Benefit Lifetime Maximum.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance the Insured's ability to perform the Activities of Daily Living and allow the Insured to remain in the Insured's Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits

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otherwise provided by the Riders. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

Caregiver Training Benefit – Caregiver Training Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in the Insured's Home. Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return to Home where the Insured can be cared for by the person receiving the training. Benefits are payable for the Covered Expenses the Insured incurs for Caregiver Training up to the Caregiver Training Benefit Lifetime Maximum.

Nonforfeiture Benefit of the EBR – Upon lapse of the EBR, the Owner is eligible for a Nonforfeiture Benefit of either the Return of Premium Benefit, as described above under Section 6, or a limited amount of paid-up long-term care benefits, as described in the EBR.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for benefits under the coverage, we must verify that the Insured is a Chronically Ill Individual, as certified by a Licensed Health Care Practitioner within the past 12 months. In addition:

- The cost incurred is a Covered Expense under the coverage and the service for such Covered Expense is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under the Riders must be in force on the dates the care is received;
- The Insured must not have exhausted the applicable limits on the specific benefits claimed, or the Maximum Benefit Limit;
- The Insured must meet the additional requirements for the specific benefits claimed; and
- The Insured must satisfy the applicable Elimination Period.

Long-Term Care Benefits	Elimination Period
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[~~30~~90] Days
Care Coordination Benefit	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[~~30~~90] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[~~30~~90] Days

10. EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions – We will not reduce or deny any claim under the Riders because of a sickness or physical or medical condition disclosed on the application.

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Non-eligible Facilities and Providers – Any facility or provider for a given benefit that does not fall within the "Definitions" section, starting on page 8, would be a non-eligible facility or provider for that benefit.

Non-eligible Levels of Care – Coverage does not include any services that do not constitute Qualified Long-Term Care Services. Care from family members is covered only where specifically indicated below in Exclusions/Exceptions and Limitations.

Exclusions/Exceptions and Limitations – We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while the Riders are not in force, except as provided in the provision.

~~**Non-Duplication –** We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in the Rider.~~

Duration – The ABR provides two years of long-term care benefits. The EBR provides between one and six years of additional long-term term care benefits, depending on the duration elected. These durations may increase or decrease depending on how the Policy and Rider benefits are used.

THIS COVERAGE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, consider whether and how the benefits of this coverage may be adjusted. One of the available Inflation Benefit Options may be elected at the time of purchase to increase the coverage. While the Insured will be underwritten in order to purchase the coverage, once the Inflation Benefit Option is in effect, no further underwriting is required. There is a premium charge for including any Inflation Benefit Option in the coverage. The premium charge varies depending on which Inflation Benefit Option is elected.

Unless rejected, one of the following will apply to the Riders:

- 5% Compound Inflation Benefit Option
- 5% Simple Inflation Benefit Option
- 3% Simple Inflation Benefit Option

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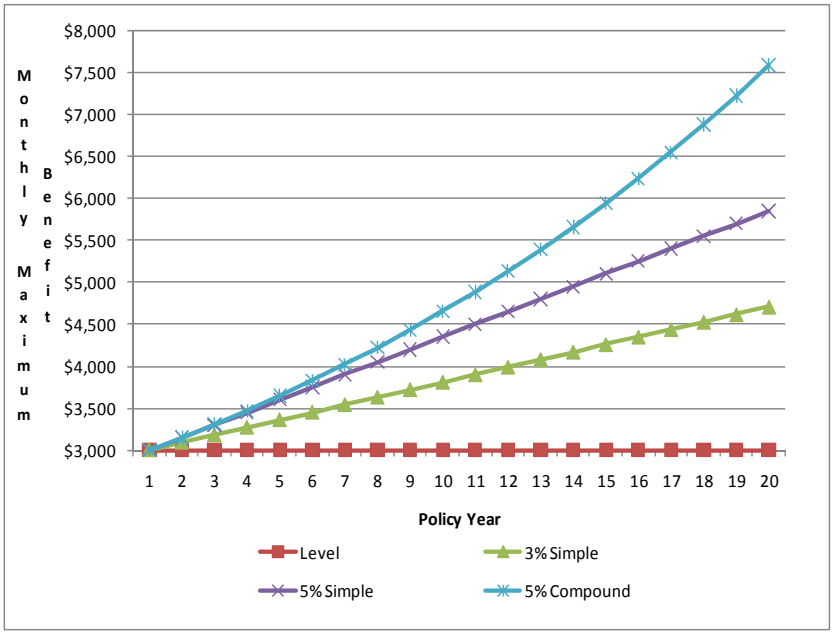
Simple Inflation Benefit Option (3% or 5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to the selected percentage of the initial Monthly Maximum Benefit Amount. The Maximum Benefit Limits will be increased by the same proportion as the Monthly Maximum Benefit Amount.

Compound Inflation Benefit Option (5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to 5% of the Monthly Maximum Benefit Amount in effect immediately prior to the increase. The Maximum Benefit Limits will also be increased on each Policy anniversary by an amount equal to 5% of the Maximum Benefit Limits in effect immediately prior to the increase.

INFLATION PROTECTION – GRAPHIC COMPARISONS

The following chart compares and contrasts benefit levels for coverage with no inflation protection and coverage with the 3% simple, 5% simple and 5% compound Inflation Benefit Options offered with the coverage. The chart assumes an initial Monthly Maximum Benefit Amount of $3,000.



The following chart shows a relative cost comparison of total premiums with and without an Inflation Benefit Option. At each issue age and gender combination, the chart shows the total premium with the Inflation Benefit Option divided by the total premium without the Inflation Benefit Option. For example, total premiums for a 35 year old female for coverage with the 5% simple Inflation Benefit Option will cost 163% of the total premiums for coverage with no Inflation Benefit Option. The chart assumes a 2 year ABR and 2 year EBR were elected.

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Issue Age	Gender	Inflation Option for 4 Year LTC Benefit			
		None	3% Simple	5% Simple	5% Compound
35	Male	100%	117%	130%	215%
	Female	100%	131%	163%	376%
45	Male	100%	121%	140%	192%
	Female	100%	132%	163%	315%
55	Male	100%	124%	150%	173%
	Female	100%	131%	163%	257%
65	Male	100%	124%	148%	162%
	Female	100%	131%	157%	245%
75	Male	100%	121%	138%	160%
	Female	100%	145%	170%	240%

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once an Insured's application is approved, coverage is provided for an Insured who is a Chronically Ill Individual as a result of Alzheimer's disease or any related degenerative and dementing illnesses.

13. PREMIUM

The single premium for the coverage will be determined based on the amount of coverage, the Inflation Benefit Option elected, if any, and the Insured's issue age and gender as described in the application and illustrated in the chart in section 11.

14. ADDITIONAL FEATURES

Underwriting – We will underwrite the Insured's application by reviewing one or more of the following: the information submitted on the application; an attending Physician's report; copies of the Insured's medical records; a medical evaluation; a telephone interview; and an in-person interview.

Added Protection Against Lapse – If the Insured's coverage terminates due to lapse, we will provide a retroactive continuation of coverage if within five (5) months of the termination date the Insured provides us with proof the Insured was a Chronically Ill Individual, beginning on or before the termination date. All past due premiums, outstanding Policy Debt prior to the date of lapse and any amount refunded due to lapse in connection with the Rider Return of Premium Benefit must be paid. In that event, the Policy and Riders will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE COVERAGE.

DEFINITIONS

In this section, we define certain terms used throughout this Outline of coverage. Defined terms are usually capitalized to show emphasis.

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ABR – means the Accelerated Benefit Rider.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is ~~engaged~~appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing ongoing Assisted Living Care and related services ~~that:~~

~~(a) Has~~. If the ~~appropriate~~ state ~~licensure or certification as an Assisted Living Facility where required;~~does not license or certify such facilities, then it must be operated pursuant to law and ~~(b) Meets~~meet all of the following ~~requirements~~standards:

- Provides ~~services and care~~Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;

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- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under the ABR or EBR. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;

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- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

EBR – means the Extended Benefit Rider.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is ~~regularly engaged in providing~~ licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or experience to provide such care. ~~The entity~~ If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:

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- Be supervised by a qualified professional such as a Registered Nurse ~~(RN),~~, a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and
- Provide ongoing supervision and training to its employees appropriate to the services to be provided~~; and~~.
- ~~Have the appropriate state licensure or certification, where required or available.~~

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified ~~or complies with the state's facility licensing requirements and provides~~to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

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Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit Limit – is the total amount of lifetime benefits payable under the ABR or EBR, as applicable, as described in the ABR or EBR.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum Benefit Amount – is the total amount of monthly benefits payable under the ABR or EBR, as applicable.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. ~~It also~~If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;

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- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services.

Policy – means the flexible premium adjustable life insurance policy Form ICC11 P11PPC to which the Riders are attached.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Riders – means the ABR and the EBR.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

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Terminal Illness Benefit Payment – means the actual dollar amount of benefit received under the Terminal Illness Benefit of the Policy.

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EXTENDED BENEFIT RIDER ("EBR") FOR LONG-TERM CARE

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This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider extends the benefits provided by the Accelerated ~~Benefits~~Benefit Rider ("ABR") for Long-Term Care. The benefits of this Rider become effective after payments for Covered Expenses under the ABR have reached the Maximum ABR Benefit Limit. This Rider reimburses the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its ~~agents~~producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy, ABR, and this Rider are received to examine and return all of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy, ABR, and this Rider, but all must be returned together. The Policy, ABR, and this Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for the Policy, ABR, and this Rider within 30 days of such a return and the Policy, ABR, and this Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy or the ABR. Terms used in this Rider, the Policy and the ABR will have the same definition unless stated otherwise in this Rider. Defined terms are usually capitalized to show emphasis.

EBR Benefit Duration – The period of coverage under this Rider. The EBR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The EBR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

In Force – means that this Rider is in effect.

Maximum EBR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum EBR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum EBR Benefit Limit will be reduced when a payment of benefit is made in accordance with the terms of this Rider.

Monthly Maximum EBR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit and Alternative Care Benefit. The initial Monthly Maximum EBR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum EBR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications.

~~LIMITATIONS OR CONDITIONS ON~~ ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum EBR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

~~If the Insured is a~~ **Chronically Ill Individual –** means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment~~, the need for Substantial Supervision must be such~~ .

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured~~:~~ meets these requirements.

~~• Does not continue to operate a motor vehicle;~~
~~• Requires assistance to take medication;~~

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- ~~Is not left alone for substantial portions of the day; and~~
- ~~If the Insured is a resident in a Nursing Home Facility or Assisted Living Facility, the Insured is not able to leave that facility without competent adult supervision.~~

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions – In addition to meeting the Eligibility for the Payment of Benefits criteria shown above, the following conditions must also be met in order for benefits to be paid under this Rider:

- The Owner must elect to claim benefits under this Rider; and
- The Covered Expense incurred for which benefits are claimed under this Rider must occur after the Maximum ABR Benefit Limit has been exhausted.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum EBR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum EBR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit; and
- Alternative Care Benefit.

LONG-TERM CARE BENEFITS

Long-Term Care Benefits – This Rider extends the benefits provided under the ABR by providing a Maximum EBR Benefit Limit and a Monthly Maximum EBR Benefit Amount, which become effective when the Maximum ABR Benefit Limit under the ABR is exhausted.

Specific Benefits – The specific benefits in the ABR to which this extension applies are the following:

- Care Coordination;
- The Care Coordination Benefit;
- The Nursing Home Benefit;
- The Assisted Living Facility Benefit;
- The Home and Community Care Benefit;
- The Alternative Care Benefit;
- The Non-Continual Alternative Care Benefit; and
- The Caregiver Training Benefit.

Differences from the ABR – When benefits are payable under this Rider, the benefits shown above will be paid as described in the ABR except for the following:

- References in the ABR to the Maximum ABR Benefit Limit will be considered to be references to the Maximum EBR Benefit Limit shown on the Policy Specifications;
- References in the ABR to the Maximum Monthly ABR Benefit Amount will be considered to be references to the Monthly Maximum EBR Benefit Amount;
- This Rider does not provide an International Benefit; and
- The Elimination Period does not apply to this Rider.

If benefits that are subject to the Maximum Monthly ABR Benefit Amount become payable partly under both this Rider and the ABR (because the Maximum ABR Benefit Limit has been exhausted during the month), the maximum amount payable under all such benefits is limited to the greater of:

- The Monthly Maximum ABR Benefit Amount; and
- The Monthly Maximum EBR Benefit Amount.

Benefits payable under the Non-Continual Alternative Care Benefit and the Caregiver Training Benefit of this Rider will:

- be reduced by the respective amounts for which payment is made under the ABR; and
- not be provided if the respective lifetime maximum benefit has been exhausted under the ABR.

The terms, conditions and exclusions of the ABR apply to the payment of benefits under this Rider unless otherwise stated in this Rider.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the ~~insured~~Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is the Monthly Maximum EBR Benefit Amount applicable on the Policy Date; and

C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times (B divided by C), where:
A. Is the existing Maximum EBR Benefit Limit;
B. Is the new Monthly Maximum EBR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum EBR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy and ABR are cancelled pursuant to the Owner's request; or
- The date the Owner has received the Maximum EBR Benefit Limit allowed.

EBR RETURN OF PREMIUM BENEFIT

EBR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the EBR Return of Premium Benefit is equal to the EBR Premium, as shown on the Policy Specifications. After issue, the EBR Return of Premium Benefit may be reduced as described in the Policy, after the reduction of the Life Return of Premium Benefit and the ABR Return of Premium Benefit.

NONFORFEITURE BENEFIT

Nonforfeiture Benefit – Upon lapse of this Rider, the Owner is eligible for one of the two options described below. The Owner can change the elected benefit at any time before lapse by sending us a Written Request. The options available are:

1. Return of Premium Benefit as described in this Rider. This option will be effective automatically unless the Owner requests otherwise in writing.
2. Shortened Benefit Period. Under this option, we will continue coverage of eligible claims until the earlier of:
    a. The death of the Insured; or
    b. The date the Nonforfeiture Benefit Limit has been reached.

Nonforfeiture Benefit Limit – is an amount equal to the greater of:
a. The Monthly Maximum EBR Benefit Amount; or
b. The EBR Premium, as shown in the Policy Specifications.

The Nonforfeiture Benefit Limit is reduced by the sum of all benefits previously paid under this Rider. The Nonforfeiture Benefit Limit will never be greater than the remaining amount payable had this Rider stayed In Force.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – This Rider will not pay benefits for any expenses incurred:

- Prior to the date the Maximum ABR Benefit Limit has been exhausted under the ABR; or
- That would have been excluded from payment under the ABR had it remained In Force (as stated in the Exclusions and Limitations provision of that rider).

CLAIMS PROVISIONS

The Claims Provisions in the ABR apply to the payment of benefits under this Rider.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

The Premiums, Lapse and Reinstatement provisions of the ABR apply to this Rider, except as modified below.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any EBR Return of Premium Benefit.

Reinstatement – If the ABR is reinstated under its Reinstatement provision, this Rider will also be reinstated. Any amount refunded due to lapse in connection with the EBR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy, the ABR and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider, the ABR and the Policy are cancelled pursuant to the Owner's request;
- The date the Owner has received the Maximum EBR Benefit Limit allowed under this Rider; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy, the ABR and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility before the date the Policy, the ABR or this Rider ended in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy, the ABR and this Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable ~~under this Rider~~ to what the ~~correct amount using~~premium paid would have purchased at the Insured's correct sex or birth date as of the Policy Date. ~~If based on the Insured's correct sex or birth date the Application would not have been accepted and this Rider not issued, we will cancel this Rider and will only be liable for the refund of all premiums paid for this Rider.~~

Fraud/Recovery – If we determine that benefits have been paid under the Policy, the ABR, or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy, the ABR, or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If, on or after the Policy Date, this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to always comply with those requirements. ~~Because~~However, because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change.

We will also inform the Owner that if they reject the change, the policy may no longer be tax-qualified under the Internal Revenue Code, and the Owner should consult a financial planning professional and independent tax advisor.

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ACCELERATED BENEFIT RIDER ("ABR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider accelerates the Policy's benefits by reimbursing the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy and this Rider are received to examine and return both of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and this Rider, but both must be returned together. The Policy and Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for both the Policy and this Rider within 30 days of such a Policy and Rider return and the Policy and Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

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DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy. Defined terms are usually capitalized to show emphasis.

ABR Benefit Duration – The period of coverage under this Rider. The ABR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The ABR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that: has the appropriate state licensure or certification as an Assisted Living Facility where required. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

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~~(a) Has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) Meets all of the following requirements:~~

- ~~Provides services and care~~Provides Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- Performance of comprehensive individualized Assessments, including reassessments as needed;
- Development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in the Insured's condition, by a Care Coordinator; and
- Coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by the Insured or Representative and determined necessary by the Care Coordinator.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

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Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under this Rider. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is ~~regularly engaged in providing~~ licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or

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experience to provide such care. ~~The entity~~ If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:

- Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and
- Provide ongoing supervision and training to its employees appropriate to the services to be provided~~; and~~.
- ~~Have the appropriate state licensure or certification, where required or available.~~

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Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified ~~or complies with the state's facility licensing requirements and provides~~to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

In Force – means that this Rider is in effect.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

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Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum ABR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum ABR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum ABR Benefit Limit will be reduced when:

- A payment of benefit is made in accordance with the terms of this Rider;
- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum ABR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit, International Benefit and Alternative Care Benefit. The initial Monthly Maximum ABR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will be reduced when:

- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. ~~It also~~If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

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Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- The Insured's functional or cognitive abilities;
- The Insured's social situation; and
- The Insured's care service needs.

Policy – means the life insurance policy to which this Rider is attached.

Policy Date – means the date the Policy and this Rider become effective.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative – means a person or entity legally empowered to represent the Insured.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

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Spouse – means the person to whom the Insured is legally married or the Insured's partner in a civil union or domestic partnership.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

~~LIMITATIONS OR CONDITIONS ON~~ ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The applicable Elimination Period has been satisfied;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum ABR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

The Owner must elect to accelerate benefits under the Policy by making a claim for benefits under this Rider.

~~If the Insured is a~~ **Chronically Ill Individual** – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment~~, the need for Substantial Supervision must be such~~.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured~~:~~ meets these requirements.

~~- Does not continue to operate a motor vehicle;~~
~~- Requires assistance to take medication;~~
~~- Is not left alone for substantial portions of the day; and~~
~~- If the Insured is a resident in a Nursing Home Facility, Hospice Care Facility, or Assisted Living Facility, the Insured is not able to leave that facility without competent adult supervision.~~

Activities of Daily Living – means the following self-care functions:

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Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

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LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Elimination Period – The applicable Elimination Period must be completed before benefits are payable. The Policy Specifications show the number of days for the Elimination Period.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum ABR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum ABR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit;
- Alternative Care Benefit; and
- International Benefit.

CARE COORDINATION

Care Coordination – Care Coordination helps the Insured identify his specific care needs and the long-term care services and programs in his area that can best meet those needs. The Insured may use a Care Coordinator to help him make the most informed decision regarding his care.

About Care Coordination – Care Coordination provides the Insured with the knowledge and training of a Care Coordinator who will review his unique situation and develop Plans of Care to meet his needs. The Care Coordinator, a Licensed Health Care Practitioner, will:

- Assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis;
- Work with the Insured to determine the specific services required;
- Develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the needs of the Insured;
- Coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and
- Help the Insured arrange for care, if desired.

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Care Coordination is Voluntary – Care Coordination is advisory only. The Insured is not required to use Care Coordination to arrange for care providers or to use the specific care providers identified in the Plan of Care. However, all the Insured's Rider benefits must be provided in accordance with an approved Plan of Care.

Limited Availability Outside United States – Care Coordination other than performing an Assessment or developing a Plan of Care is not available for care received outside the United States.

Transition Planning – If the Insured desires, the Care Coordination Provider will recommend a transition plan that specifies how the Insured's care needs may be met once:

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- The Insured has exhausted the benefits under his Rider; or
- The Insured is no longer a Chronically Ill Individual but needs some continued level of assistance.

Care Coordination Provided by Us – Care Coordination provided by us does not require a claim for benefits under this Rider. Any Care Coordination provided by us will not reduce the Maximum ABR Benefit Limit or the Monthly Maximum ABR Benefit Amount.

CARE COORDINATION BENEFIT

Care Coordination Benefit – Benefits are payable for Covered Expenses for Care Coordination that is not performed by us. The Covered Expenses and the amount of the benefit we pay are described below.

Covered Expenses – Covered Expenses for Care Coordination means expenses the Insured incurs, while the Insured is a Chronically Ill Individual, for Care Coordination that is not performed by us.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Care Coordination during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NURSING HOME BENEFIT

Nursing Home Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in a Nursing Home Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for a Nursing Home Facility means expenses the Insured incurs during his Confinement in a Nursing Home Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Nursing Home Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Nursing Home Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Nursing Home Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses also include fees charged for Hospice Care provided by a Hospice Care Facility.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

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ASSISTED LIVING FACILITY BENEFIT

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in an Assisted Living Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for an Assisted Living Facility means expenses the Insured incurs during his Confinement in an Assisted Living Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Assisted Living Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Assisted Living Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Assisted Living Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured was a Chronically Ill Individual and incurring Covered Expenses during the month.

HOME AND COMMUNITY CARE BENEFIT

Home And Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for Home and Community Care means fees charged for the following services when provided to the Insured by a Home Health Care Agency:

- Home Health Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care and Respite Care.

Covered Expenses also includes fees charged for Adult Day Care provided by an Adult Day Care Center.

Criteria for Receiving Care from an Independent Provider – The Independent Provider must be licensed or certified in the state where the care will be provided, if licensing or certification is required ~~or available~~ for the services provided. ~~A home health aide or certified nursing assistant~~ An Independent Provider must present written proof of completion of an established training course or written proof of licensure or certification. The education must include training in safely assisting persons with all Activities of Daily Living. We will accept as proper credentials the ~~home health aide's or certified nursing assistant's~~Independent Provider's inclusion in a government-sponsored nurse aide registry. If the state in which the Insured lives does not require or accept licensure or certification for Independent Providers, then we may approve benefits for an Independent Provider if we can determine that the individual is qualified by training and experience to provide Home Health Care Services and Maintenance or Personal Care Services.

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How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care during the policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

INTERNATIONAL BENEFIT

International Benefit – The Insured is eligible to receive cash benefits when Confined in a Nursing Home Facility outside the United States. The conditions under which we will pay this International Benefit and the amount of benefit payable are described below.

Conditions for International Benefits – This cash benefit will be available beginning on the day the Insured first satisfies the Eligibility for the Payment of Benefits requirements and is Confined in a Nursing Home Facility outside the United States. This benefit is in lieu of all other benefits under this Rider.

The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and Confined in a Nursing Home Facility outside the United States. For proof that the Insured is Confined in a Nursing Home Facility outside the United States, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. Proof that the Insured is a Chronically Ill Individual must be provided every 90 days. The cost for providing any of the proof required for this benefit is the responsibility of the Owner.

The Insured must notify us in advance to receive benefits under this provision. The notice must be made in writing and in English. If we are not notified prior to the date of admission to the Nursing Home Facility, then the first date the Insured is eligible for this benefit is the date we receive satisfactory written notice of an eligible Nursing Home Facility stay.

The International Benefit will end at the earliest of the date on which the Insured:

- Has received the Maximum ABR Benefit Limit;
- Is no longer a Chronically Ill Individual;
- Is no longer Confined in a Nursing Home Facility; or
- Returns to the United States.

No other benefit under this Rider is payable during a Policy month for which the Insured receives the International Benefit.

If the Insured is currently in claim in the United States, the Insured cannot leave the United States and be eligible for the International Benefit.

How Much We Will Pay – Benefits are payable for each month that the Insured meets the Conditions for International Benefits. We will pay the Monthly Maximum Benefit ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and Confined in a Nursing Home Facility each day of the Policy month, the benefit for the month will be pro-rated. It will consist of 1/30 of the Insured's Monthly Maximum Benefit ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual during the month.

All benefit payments will be made in U.S. dollars.

ALTERNATIVE CARE BENEFIT

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Alternative Care Benefit (For expenses not otherwise covered, but authorized by us) **–** We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in this Rider.

Covered Expenses – Benefits and services can be authorized if we determine that they:

- Are cost-effective;
- Are appropriate to the Insured's needs;
- Are consistent with general standards of care;
- Provide the Insured with an equal or greater quality of care; and
- Are for and constitute Qualified Long-Term Care Services.

Any benefits, treatments, or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician.

We reserve the right to decline to authorize benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once the Insured has exhausted the benefits under this Rider. Agreement to participate in Alternative Care Benefits will not waive any of the rights the Insured or we have under this Rider.

Alternative Care Benefits may be discontinued at any time without affecting the Insured's right to the benefits otherwise available under this Rider.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NON-CONTINUAL ALTERNATIVE CARE BENEFIT

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Non-Continual Alternative Care Benefits. The amount of the benefit we will pay and the conditions under which we will pay this benefit are described below.

Covered Expenses – Covered Expenses for the Non-Continual Alternative Care Benefit means Covered Expenses the Insured incurs for the following, as described below:

- Home Modification; and
- Durable Medical Equipment.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Our determination of whether the Home Modification is a cost-effective alternative will occur within a reasonable period of time. Benefits are not payable for any expenses incurred prior to the date of agreement between the Owner, the Insured, and us. Agreement to participate in Home Modification under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Rider.

Covered Home Modification Expenses – Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to the Insured's Home is a cost-effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance his ability to perform the Activities of Daily Living and allow the Insured to remain in his or her Home safely.

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Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Durable Medical Equipment under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. The Durable Medical Equipment must be located in the Insured's Home.

Covered Durable Medical Equipment Expenses – Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in the Insured's Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment. This benefit is subject to the Non-Continual Alternative Care Benefit Lifetime Maximum shown on the Policy Specifications.

CAREGIVER TRAINING BENEFIT

Caregiver Training Benefit – Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in his or her Home.

Covered Expenses – Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return Home, where the Insured can be cared for by the person receiving the training.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Caregiver Training. This benefit is subject to the Caregiver Training Benefit Lifetime Maximum shown on the Policy Specifications.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is the Monthly Maximum ABR Benefit Amount applicable on the Policy Date, adjusted for withdrawals and for benefits paid under the Terminal Illness Benefit; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times (B divided by C), where:

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A. Is the existing Maximum ABR Benefit Limit;
B. Is the new Monthly Maximum ABR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum ABR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request; or
- The date the Maximum ABR Benefit Limit has been paid.

ABR RETURN OF PREMIUM BENEFIT

ABR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the ABR Return of Premium Benefit is equal to the ABR Premium, as shown on the Policy Specifications. After issue, the ABR Return of Premium Benefit may be reduced (but not below zero) as described in the Policy, after the reduction of the Life Return of Premium Benefit.

EFFECT OF RIDER ON POLICY

Effect of Benefit Payment Under This Rider on Death Proceeds – We reserve the right to withhold any portion of the Death Proceeds that would otherwise be payable for a reasonable period of time under the facts and circumstances to allow verification that we have received all remaining claims for Covered Expenses incurred before the date of death of the Insured.

Effect of Benefit Payment Under This Rider on Policy Withdrawals – Once a claim for benefit payment under this Rider has been received by us, no withdrawals may be made under the Policy.

Effect of Benefit Payment Under This Rider on Policy's Face Amount – Benefit payment under this Rider will reduce the Policy's Face Amount. The reduction in the Policy's Face Amount after payment of the benefit is calculated as A times the result of (B divided by C) where:

A. Is the Policy's Face Amount prior to payment of the benefit;
B. Is the benefit payment; and
C. Is the Maximum ABR Benefit Limit before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Accumulated Value – Benefit payment under this Rider will reduce the Policy's Accumulated Value. The Policy's Accumulated Value after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Policy's Accumulated Value prior to payment of the benefit;

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B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy Debt – If there is a loan outstanding under the Policy at the time a benefit under this Rider is payable, a portion of the benefit will be applied towards repayment of the loan. The amount of the benefit that will be allocated as a loan repayment will be calculated as A times the result of (one minus (B divided by C)) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

The Policy Debt after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Coverage Charge – Benefit payment under this Rider will reduce the Policy's Coverage Charge. The Coverage Charge after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Coverage Charge prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

EFFECT OF POLICY ON RIDER

Effect of Withdrawals on This Rider – Any withdrawal made under the Policy will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

The new Maximum ABR Benefit Limit after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

Effect of Terminal Illness Benefit Payment on this Rider – Any amount paid under the Terminal Illness Benefit will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

The new Maximum ABR Benefit Limit after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

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A. Is the Maximum ABR Benefit Limit before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

EXCLUSIONS AND LIMITATIONS

Benefits under this Rider will not be limited or excluded by type of illness, treatment, medical condition or accident, except as provided in this section. In this section, we state the conditions under which payment will be limited, or not made at all, even if the Insured otherwise qualifies for benefits. These conditions apply to all benefits provided by this Rider.

Exclusions – This Rider will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - He or she is a regular employee of an organization which is providing the treatment, service or care; and
  - The organization receives the payment for the treatment, service or care;
- Care or services for which no charge is made in the absence of insurance;
- Care or services provided outside the United States of America, except as provided for under the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while this Rider is not In Force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion – We will not reduce or deny any claim under this Rider because of a sickness or physical or medical condition disclosed on the Application.

~~**Non-Duplication With Other Plans –** We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in this Rider. The Care Coordinator can assist in identifying other insurance benefits to which the Insured is entitled that can be applied to meet actual expenses.~~

CLAIMS PROVISIONS

In this section, we describe when we must be notified of a claim; what to send us; how we evaluate and pay claims; and other rights and responsibilities under the Rider.

The Insured's Role in the Claims Process – Early awareness by us will facilitate a timely claim review. It is important that the Owner or Insured notify us immediately when the Owner or Insured thinks the Insured is eligible for benefits under this Rider. To file a claim, the Owner or Insured may call us, notify us in writing or submit a completed claim form we provide.

Notify Us as Soon As Possible – We can handle the claim request more efficiently if we are notified within 30 days after the Insured is eligible for benefits or as soon as reasonably possible. We prefer to be notified as soon as the Insured first becomes disabled to the extent that the Insured may soon need care

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covered by this Rider. Notify us even if the Owner or Insured is unsure, and we can help determine whether the Insured is eligible for benefits.

How Claims Are Evaluated – When notice of claim is received, we will collect the information we need to verify whether the Eligibility for the Payment of Benefits requirements have been met. We may need to contact the Insured's Physician or other care provider and to review the Insured's medical records. Based on our evaluation of this information, we will verify the Insured's eligibility for benefits. We will not pay benefits until we verify eligibility for benefits. If we determine that the Insured is eligible for benefits, we will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordinator.

Cross Border Rules – Benefits will be paid for similar services obtained in a state other than the Policy state of issue if benefits for those services would have been paid in the Policy state of issue, irrespective of any facility licensing, certification or registration requirement (or similar requirements) differences between the states.

Claim Forms – We will provide claim forms for the filing of proofs of loss when we receive the notice of claim. If the Owner, Insured or Insured's Representative does not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending us a letter which describes the occurrence, the character and the extent of the loss for which the claim is made. That letter must be sent to us at our Administrative Office within the time noted below under Proof of Loss.

Proof of Loss – In the case of a claim for continuing loss for which this Rider provides any periodic benefits, written proof of loss must be given to us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be given to us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than one year after the date the proof is otherwise required.

Written Notification – The Owner will be notified in writing whether or not the Insured is eligible for benefits. We will provide notification within ten days of receiving all the required information. If the Owner wants to receive information related to ~~such~~a denial of benefits, that information will be sent to the Owner within 60 days of receipt of his or her written request, or as required by the applicable laws and regulations where the policy is delivered or issued for delivery.

When Benefit Payments Will Be Made – Once the applicable Elimination Period has been completed, benefit payments will be made upon our receipt of the required written claims and evidence of the Insured's continued eligibility. Benefit payments will be made as long as the loss and our liability continue. When a claim is paid, the Owner will receive an Explanation of Benefits from our Administrative Office.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner unless otherwise assigned. Any benefits to which the Owner is entitled that are unpaid at the Insured's death will be payable to the Owner. If benefits are payable to an estate, we may pay a portion of those benefits, up to $5,000, directly to the Owner's spouse or someone related to the Owner by blood or marriage who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examination – At our expense, we have the right to require an examination of the Insured's functional or cognitive status when a claim is made and at reasonable intervals while benefits are being claimed.

How the Owner or Insured Can Appeal a Claim Decision – If the Owner or Insured disagrees with our decision regarding a claim, the Owner may request in writing within 60 days of that decision that we reconsider the claim. Any internal review of claim decisions will be consistent with the applicable laws and regulations where the policy is delivered or issued for delivery. The Owner or Insured should submit

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any additional information that the Owner or Insured feels we need to review our decision. The Owner or Insured should include the names, addresses, and phone numbers of any care providers we should contact to learn more about the loss. The Owner is responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider our decision and send written notification of the results to the Owner. If we deny the appeal request and the Owner wants to receive written information related to such denial, that information will be sent within 60 days of receipt of the written appeal request. This Rider will comply with any requirements regarding external review of claim decisions, consistent with the applicable laws and regulations where the policy is delivered or issued for delivery.

Legal Actions – No action may be brought to recover under this Rider until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given. Any legal cause of action shall conform to the laws of the state in which the policy was delivered or issued for delivery.

Direct Payment of Benefits to Care Provider (Assignment of Benefits) – The Owner may instruct us to pay benefits due under this coverage directly to a Nursing Home Facility, Assisted Living Facility, Hospice Care Facility, Adult Day Care Center or Home Health Care Agency providing the care for which we are reimbursing expenses. The care provider must also agree to the assignment of benefits. The Owner must notify us by Written Request. An assignment will take place only when recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed~~.~~, unless otherwise specified by the Owner. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of any assignment.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

In this section, we describe such things as the premium for this Rider and the reinstatement provisions.

Non-Cancellable – This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision. The premiums under this Rider are paid by a single premium on or before the Policy Date and cannot be increased.

Paying Premiums, Single Premium – In order for this Rider to be In Force, a single premium covering the entire cost of the Rider must have been paid to us on or before the Policy Date.

Protection Against Unintentional Lapse – In order to protect the Policy and Rider against unintentional lapse, at least one person in addition to the Owner must be designated to receive notice of lapse or termination or the Owner must sign a waiver electing not to designate an additional person to receive notice. The Owner may change this designation at any time. To do so, notify us in writing. We will remind the Owner in writing every two years of this opportunity.

Grace Period – The Grace Period provision in the Policy applies to this Rider.

Notification of Non-Payment – The Notification of Non-Payment provision in the Policy applies to this Rider.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any ABR Return of Premium Benefit.

Reinstatement – If the Policy is reinstated under its Reinstatement provision, this Rider is also eligible to be reinstated provided that such reinstatement occurs within six months from the end of the Grace Period. After the six-month period, this Rider will not be reinstated, even if the Policy is reinstated.

Added Protection Against Lapse – If coverage terminates due to lapse, we will provide a reinstatement of coverage as specified below, if certain conditions are met. To be eligible for this reinstatement, the Insured

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must provide us proof that the Insured was a Chronically Ill Individual, beginning on or before the date of termination.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner that demonstrates that the Insured was a Chronically Ill Individual. The proof must be provided to us within five months of the termination date. The Owner must pay all past due premiums and outstanding Policy Debt prior to the date of lapse. In that event, the Policy and this Rider will be reinstated as of the date of that termination without interruption of insurance for that period.

Requirements for Reinstatement – If this Rider is eligible to be reinstated, in order for us to evaluate your request for reinstatement, you must satisfy the requirements for reinstatement of the Policy and this Rider. ~~Unless reinstated as described in Added Protection Against Lapse, we reserve the right to charge a fee not to exceed $500 to evaluate insurability in connection with your reinstatement application.~~

Reinstatement of the Policy and this Rider is effective upon our approval of your reinstatement application. If we issue a temporary insurance agreement in connection with the premium tendered for reinstatement, and we do not act to approve the application, the reinstatement is effective on the 45th day following the date of the temporary insurance agreement unless we have given notice to the Owner of our disapproval of the application prior to the expiration of the 45 day time limit.

If approved, the Policy and this Rider will be reinstated retroactive to the date of termination of coverage. In all other respects, including benefits for Covered Expenses, the Owner will have the same rights under this Rider as prior to the termination. Any amount refunded due to lapse in connection with the ABR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request;
- The date the Maximum ABR Benefit Limit has been paid; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility before the date of termination in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;

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- The date the Insured is no longer Confined in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Elimination Period and Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy and Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

QUALIFIED LONG-TERM CARE SERVICES

Benefit for Qualified Long-Term Care Services – This Rider provides benefits for Qualified Long-Term Care Services received by a Chronically Ill Individual provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. Benefits for Qualified Long-Term Care Services are conditioned on a determination that the Insured is a Chronically Ill Individual.

Certification by A Licensed Health Care Practitioner – Certification that the Insured is a Chronically Ill Individual shall be performed by a Licensed Health Care Practitioner. Such certifications may be performed by a Licensed Health Care Practitioner at our direction as is reasonably necessary with respect to a specific claim, except that when a Licensed Health Care Practitioner has certified that the Insured is a Chronically Ill Individual and the Owner or Insured has made a claim for benefits under this Rider, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period starting on the date of certification.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable ~~under this Rider~~ to what the ~~correct amount using~~premium paid would have purchased at the Insured's correct sex or birth date as of the Policy Date~~. If, based on the Insured's correct sex or birth date, the Application would not have been accepted and this Rider not issued, we will cancel this Rider and will only be liable for the refund of all premiums paid for this Rider~~.

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Fraud/Recovery – If we determine that benefits have been paid under the Policy or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If, on or after the Policy Date, this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to always comply with those requirements. ~~Because~~However, because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change. We will also inform the Owner that if they reject the change, the policy may no longer be tax-qualified under the Internal Revenue Code, and the Owner should consult a financial planning professional and independent tax advisor.

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PACIFIC LIFE INSURANCE COMPANY
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P.O. Box 2030 • Omaha, NE 68103-2030
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www.PacificLife.com]

APPLICATION FOR [PACIFIC PREMIERCARE]

For Individual Life Insurance with Long-Term (LTC) Benefits.

PROPOSED INSURED

1A. Name: First | MI | Last

B. Gender ☐ Male ☐ Female

C. Residence Address: Street | City | State | Zip Code

D. Date of Birth | E. Place of Birth (State/Country) | F. Soc. Sec. # | G. Telephone # (include area code)

2A. Employer's Name | B. Occupation

3A. Proposed Insured is a: ☐ U.S. Citizen ☐ U.S. Permanent Resident ☐ Foreign National

B. If Foreign National, provide Country | C. Visa Type | 4A. Gross Annual Income $ | B. Net Worth $

5. Is the Proposed Insured married or in a legally recognized civil union or domestic partnership? ☐ Yes ☐ No

POLICY INFORMATION

1. Face Amount $ | 2. Single Premium $ | 3. Amount submitted with Temporary Insurance Agreement (TIA) $

4. Long-Term Care (LTC) Benefit Duration: (Includes 2 year Accelerated Benefit Rider plus 0-6 years of Extended Benefit Rider.)
☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years ☐ 7 Years ☐ 8 Years

5. Inflation Benefit Option (select one)
☐ 3% Simple ☐ 5% Simple ☐ 5% Compound ☐ Reject All Inflation Benefit Options

PRIMARY POLICYOWNER (Complete if other than Proposed Insured.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all trustees to sign? ☐ Yes ☐ No (If No, indicate in Remarks who is required to sign.)

ADDITIONAL POLICYOWNER (If more than one individual is named as policyowner, they will own policy as joint tenants with rights of survivorship unless otherwise stated.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all Trustees to sign? ☐ Yes ☐ No (If No, indicate who is required to sign in Remarks.)

Payor Of Premium

1. Payor of premium is (Check one): ☐ Proposed Insured ☐ Primary Policyowner ☐ Additional Primary Policyowner ☐ Other

2A. If "Other" indicate Name of Payor

B. Address: Street City State Zip Code

Protection Against Unintended Lapse

I, the Policyowner, understand that I have the right to designate at least one person other than myself to receive notices of lapse or termination of this policy, which contains long-term care benefits. I also understand that I have the opportunity to change this written designation at any time. My selection is as follows:

1A. ☐ I elect NOT to designate another person to receive notice of lapse or termination.

B. ☐ I designate the person listed below to receive copies of any notice of lapse or termination.

C. Name

D. Address: Street City State Zip Code

Primary Beneficiary (If percentages are left blank, all named Primary Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Contingent Beneficiary (If percentages are left blank, all named Contingent Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Certification Of Policyowner's Taxpayer Identification Number

Under penalties of perjury, I, the Policyowner, certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen or other U.S. person (defined in the instructions in item 3 of the Certification on the official IRS Form W-9).**

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Tax Reporting On Distributions To Foreign Nationals

While Pacific Life Insurance Company (PLIC) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, PLIC does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, PLIC's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. PLIC does not provide tax or legal advice, and nothing contained herein should be construed as such.

Remarks

Existing Insurance And Replacement Information For Proposed Insured

	YES	NO
1. Do you have any existing life insurance or annuity contracts, including those with long-term care (LTC) coverage?	☐	☐
2A. Do you have another long-term care insurance policy or certificate (including a health care service contract or health maintenance organization contract), whether existing or pending? (If Yes, provide details in the chart below.)	☐	☐
B. Did you have another long-term care insurance policy or certificate in force during the last 12 months that has terminated? (If Yes, provide details in the chart below.)	☐	☐

Company	Coverage Type		Policy Status			Termination Date
	LTC	Health	Existing	Pending	Terminated	

	YES	NO
3. Are you covered by Medicaid?	☐	☐
4. Have you ever applied for life insurance, long-term care, health or disability insurance and been declined, postponed or offered on a basis other than as applied-for? (If Yes, provide details in Remarks.)	☐	☐
5A. Do you intend to stop premium payments, replace, surrender, forfeit, assign to the insurer, or take a cash withdrawal or loan from any life insurance policy or annuity contract to pay premiums on the applied-for policy? (If Yes, provide details in the chart below.)	☐	☐
B. Do you intend to replace any of your medical or health insurance coverage, including any of your long-term care coverage, with this applied-for policy? (If Yes, provide details in the chart below.)	☐	☐

Policy #	Coverage Type						Company	Amount	1035 Exchange
	Life	Life+ LTC	Annuity	Annuity + LTC	LTC	Health			

General Information (Provide details in Remarks)

	YES	NO
1. Are you working at least 24 hours per week outside the home?	☐	☐
2. Have you missed more than one consecutive week of work due to illness or injury in the past 24 months?	☐	☐
3. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember?	☐	☐
4. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing?	☐	☐
5. Do you have regular exercise routines or hobbies that require physical activity?	☐	☐
6. Do you intend to travel or reside outside the United States within the next 2 years?	☐	☐
7. Have you been convicted of a felony within the past 5 years?	☐	☐
8. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?	☐	☐

Proposed Insured's Physician Information

1A. Provide full name, address, and phone number of ☐ Primary Physician ☐ Specialty Physician

B. Physician Name | C. Telephone # (include area code)

D. Address: Street | City | State | Zip Code

2. Date and reason of last visit:_____

3. Tests performed & treatment received:_____

Remarks

MEDICAL INFORMATION (Provide details to any Yes answers in Remarks. If more space is needed, use an additional sheet.)

	Yes	No
1. Have any of your immediate family members (parents, brothers or sisters) prior to age 60 been diagnosed with polycystic kidney disease or Huntington's chorea?	☐	☐
2. Currently, or within the past ~~10~~ 5 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance, or any other form of disability insurance?	☐	☐
3. Height:_____ Weight:_____ Has your weight changed 10 pounds or more in the past 2 years?	☐	☐
4. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
5. Currently, or within the last 5 years, have you had or do you need or receive assistance with any of the following: laundry, cleaning, shopping, use of transportation, telephone use, meal preparation, managing your finances or managing your medication?	☐	☐
6. Currently, or within the last 5 years, have you had or do you use a wheelchair, walker, cane, quad cane, scooter, oxygen, catheter, dialysis machine, or other mechanical device?	☐	☐
7. Within the last 5 years have you been confined or ~~recommended admission~~ been given medical advice by a member of the medical profession to be admitted to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility or attended adult day care?	☐	☐
8. Are you currently living in an Assisted Living facility or Independent Community?	☐	☐
9. Within the last 5 years, have you had or been ~~advised~~ given medical advice by a member of the medical profession to have a check-up, EKG, x-ray, CT scan, blood, or urine test, or any other diagnostic test, except for a test for the Human Immune Deficiency Virus (HIV) infection?	☐	☐
10. Within the last 5 years, have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been ~~advised or recommended~~ given medical advice by a member of the medical profession to have any hospitalization or surgery which has not been scheduled or completed?	☐	☐
11. Except for HIV, have you ever been ~~told you have, been~~ diagnosed, ~~with or been~~ treated, tested positive for, ~~by a physician~~ or been given medical advice by a member of the medical profession and/or taken medication for:		
a. Alzheimer's disease, dementia, forgetfulness, memory loss, or any other cognitive impairment?	☐	☐
b. Chest pain, angina, congestive heart failure, heart disease, heart murmur, coronary artery disease, peripheral vascular disease, atrial fibrillation, high blood pressure, or other disorders of the heart or blood vessels?	☐	☐
c. Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Muscular Dystrophy, Huntington's chorea, or Systemic Lupus?	☐	☐
d. Ulcers, colitis, jaundice, cirrhosis, chronic hepatitis, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney, or urinary bladder?	☐	☐
e. Transient ischemic attack, stroke or paralysis?	☐	☐
f. Syncope, vertigo, loss of balance, tremor or falls, seizures, fainting, dizziness, or epilepsy?	☐	☐
g. Chronic fatigue, fibromyalgia, or polymyalgia rheumatica?	☐	☐
~~h. Any nervous or mental disorder or received counseling for anxiety, depression, schizophrenia, stress, or any other emotional condition?~~	~~☐~~	~~☐~~
~~l~~h. Cancer, leukemia, lymphoma, malignant melanoma, or tumors or cysts of any kind, whether malignant or benign?	☐	☐
~~j~~i. Arthritis, Rheumatoid Arthritis, gout, Osteoporosis, or any disorder of the back, spine, muscles, nerves, bones, or joints?	☐	☐
~~k~~j. Diabetes, thyroid, or other endocrine or glandular disorder?	☐	☐
~~l~~k. Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells, or bone marrow, or any lymph node disorder?	☐	☐
~~m~~l. Asthma, emphysema, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD), allergies, sleep apnea, or any other disorder of the respiratory system?	☐	☐
~~n~~m. Any disorder of the eyes, ears, nose, or throat?	☐	☐
~~o~~n. Any disorder of the testicles, prostate, breasts, ovaries, uterus, or cervix?	☐	☐
~~p. Any mental or physical disorder not listed above?~~	~~☐~~	~~☐~~
12. Within the last 5 years, have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession and/or taken medication for anxiety, depression or any psychiatric or mental health disorder?	☐	☐
~~12~~13. What, if any, other medications do you take regularly? (Provide details in Remarks.)		
~~13. Have you ever tested positive for exposure to HIV infection or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?~~	~~☐~~	~~☐~~
14. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquire Immune Deficiency Syndrome (AIDS)?	☐	☐
~~14~~15. Have you used tobacco products (cigarettes, cigars, pipe) during the past 48 months? If "yes", provide amount used and frequency. _____ If quit, when was tobacco last used?_____	☐	☐
~~15~~16. Do you use alcoholic beverages? If Yes, provide type, frequency & amount:	☐	☐

~~16~~17. Have you ever ~~been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medications, prescribed or not~~ received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐ ☐

~~17~~18. Within the last ~~10~~ 5 years have you:

a. Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens? ☐ ☐

b. Used any tranquilizers, sedatives or narcotic drugs or any prescription drug outside a physician's instructions? ☐ ☐

REMARKS

Declarations

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

1. Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by PLIC as indicated under the title Endorsement, where permitted. All other changes made to the application or policy by PLIC will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears in the Producer Certification section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
3. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire single premium is paid only if at that time the Proposed Insured is alive~~, and all answers in this application and on the Statement of Good Health & Insurability that are material to the risk are still true and complete~~.
4. If I have given money and received a TIA, I understand that if the Proposed Insured dies before a policy is delivered; the death benefit will be limited to the TIA coverage limit.
5. PLIC may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a Department of Motor Vehicle report or other questionnaire, test or a prescription drug or medication report.

~~6. I must inform the Producer or PLIC in writing of any changes in the health of the Proposed Insured or if any of the statements or answers on this application change prior to delivery of the policy.~~

~~7. My statements and answers in this application must continue to be true as of the date I receive the policy.~~

6. No Producer is authorized to make or change contracts or insurance policies on the behalf of PLIC and no Producer may alter the terms of this application, the TIA, or the policy, nor does the Producer have the authority to waive any of PLIC's rights or requirements.
7. The Producer will receive compensation in connection with the sale of this policy.
8. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Producer or PLIC about the specific premium and risk class referenced in my policy.
9. I represent that all parties have an insurable interest in the life of the Proposed Insured.
10. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
11. The Proposed Insured received the Disclosure Notice and Privacy Notice — Health (HIPAA).
12. I HAVE READ the completed Application and all related forms for [Pacific PremierCare] before signing below. All statements and answers on this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief.
13. For purposes of this application, the proposed insured is considered the applicant, unless a policyowner is also indicated. In such case, the policyowner is considered the applicant.
14. This application will be attached to and made part of the policy.

Inflation Benefit Option

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection.

☐ I hereby **REJECT** the 5% compound Inflation Benefit Option and apply for the Inflation Benefit Option as shown in the Policy Information section, on page 1, question 5.

☐ I hereby **REJECT** all Inflation Benefit Options, including the 5% compound Inflation Benefit Option.

New Business Date Stamp (For Internal Use Only)

Modified Endowment Contract (MEC) Status

The policy is expected to be or become a MEC: ☐ Yes (Policyowner must initial below) ☐ No

Regarding Distributions:

- Distributions from the policy, including those taken during the two years prior to the policy becoming a MEC, can result in earlier income taxation.
- Distributions include (but may not be limited to) pre-death disbursements such as withdrawals, policy loans (including interest not paid when due), surrenders, and cash dividends, and also transfers of ownership and assignment of policy values.
- The taxable portion of any Distribution taken before age 59 ½ may be subject to a 10% penalty by the IRS. This 10% penalty always applies if the MEC owner is not treated as a natural person for tax purposes; e.g. is a corporation or trust.
- For purposes of determining the taxable portion of Distributions, federal tax law provides that all MECs issued by the same insurance company to the same Policyowner during any calendar year shall be treated as one MEC.
- PLIC will report income relating to such Distributions to the IRS as required by federal law and regulations.

Additional Information:

- Once a policy becomes a MEC that status cannot change. Any policy received in exchange for a MEC policy will also be considered a MEC.
- For specific questions regarding the taxation of your MEC policy, please consult your tax advisor.

INITIAL HERE ☐ **By initialing here, the Policyowner confirms their understanding that the policy to be issued is now or will become a MEC at or after issue, and accepts MEC status for the policy.**

Signatures

INITIAL HERE ☐ By initialing here, the Policyowner confirms they received the Outline of Coverage, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Life Insurance Buyer's Guide, and A Shoppers Guide to Long-Term Care Insurance.

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

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

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust) have been met.

You represent that you have read and reviewed the answers in this application and confirm they are true as of the below date that this application is signed.

CAUTION: If your answers on this application are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

SIGNED IN:

City	State

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE **X**

Proposed Insured's Signature

SIGN HERE **X**

Policyowner's Signature, if other than Proposed Insured, and include **Title,** if Corporation, Trust, or Business Entity.

SIGN HERE **X**

Additional Policyowner's Signature & Title, if applicable

Producer's Certification

	Yes	No
1. Does the Insured have any existing life insurance or annuities, including those with LTC coverage?	☐	☐
2. Do you know or have any reason to believe that a replacement of insurance is involved?	☐	☐
3. I have discussed the appropriateness of replacement, followed applicable state laws, PLIC's written guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If No, explain on an additional sheet.)	☐	☐
4. Based upon my review of, among other things, the Policyowner's and Proposed Insured's age, income, net worth, tax and family status, and current plan of insurance, I certify that the purchase of this policy meets the Policyowner's insurance needs and financial objectives, and is consistent with PLIC's suitability standards. I have documented and will retain my suitability analysis and conclusions.	☐	☐

5. List below any other Health Insurance you have sold to the Proposed Insured that is currently in force, or purchased within the last 5 years and no longer in force. (If No, explain on an additional sheet.)

Company	Policy Number	Year of Issue	Policy Status
			☐ In force ☐ No longer in force
			☐ In force ☐ No longer in force

I have reviewed the application and all related forms with the Insured and Policyowner(s).

SIGN HERE **X**

Soliciting Producer's Signature

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

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

Residents of this state who purchase life insurance, annuities or health & 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 72201-1904

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

The state law that provides for this safety net is called the Arkansas Life and 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 disability insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, 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 nonaffiliated 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.

IMPORTANT NOTICE

In the event you need to contact someone about this policy for any reason, please contact the Producer/Representative who delivered the policy to you.

PRODUCER/REPRESENTATIVE'S NAME: _____

PRODUCER/REPRESENTATIVE'S ADDRESS: _____

PRODUCER/REPRESENTATIVE'S TELEPHONE NUMBER:_____

If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

PACIFIC LIFE CUSTOMER SERVICE
45 ENTERPRISE DRIVE
ALISO VIEJO, CA 92656
(800) 800-7681

If you have been unable to contact or obtain satisfaction from the company or the Producer/Representative who delivered the policy to you, you may contact the Arkansas Bureau of Insurance at:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 W. THIRD STREET
LITTLE ROCK, AR 72201-1904
(501) 371-2640
(800) 852-5494

PACIFIC LIFE INSURANCE COMPANY

45 Enterprise Drive · Aliso Viejo · California · 92656

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

RE: P11PPC

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

Signed for the Company at Aliso Viejo, California on 10/18/2011

SIGNATURE

Thomas S. Beadleston

NAME

Vice President

TITLE

Contact Person:
Greg Guzman
Compliance Analyst, Product Compliance, 800-800-6416, extension 8483.

PACIFIC LIFE INSURANCE COMPANY

45 Enterprise Drive · Aliso Viejo · CA · 92656

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

RE: P11P1I

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

Signed for the Company at Aliso Viejo, California on 9/19/11

SIGNATURE

Lawrence Hersh, FSA, MAAAA

NAME

Assistant Vice President

TITLE

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/23/2011	Supporting Document	Statement of Variability	10/19/2011	Statement of VariabilityA11PPC - Generic.pdf Statement of VariabilityA11SOH - Generic.pdf Statement of VariabilityA11TIA - Generic.pdf Statement of VariabilityE11LRD - Generic.pdf Statement of VariabilityN11OOC - Generic.pdf (Superceded) Statement of VariabilityP11PPC - Generic.pdf (Superceded) Statement of VariabilityR11ABR - Generic.pdf Statement of VariabilityR11EBR - Generic.pdf Statement of VariabilityR11AVT - Generic.pdf
10/19/2011	Supporting	Certificatons	10/27/2011	Arkansas Certification -

	Document			P11PPC.pdf
08/23/2011	Form	Flexible Premium Adjustable Life Insurance	10/19/2011	P11PPC.pdf (Superceded)
08/23/2011	Form	Accelerated Benefit Rider (“ABR”) for Long-Term Care	10/19/2011	R11ABR.pdf (Superceded)
08/23/2011	Form	Extended Benefit Rider (“EBR”) for Long-Term Care	10/19/2011	R11EBR.pdf (Superceded)
08/23/2011	Form	Aviation Exclusion Rider	10/19/2011	R11AVT.pdf (Superceded)
08/23/2011	Form	Outline of Coverage	10/19/2011	Outline of Coverage.pdf (Superceded)
08/23/2011	Form	Application for Pacific PremierCare for Individual Life Insurance with Long-Term Care (LTC) Benefits	10/19/2011	A11PPC.pdf (Superceded)
08/23/2011	Form	Statement of Good Health and Insurability	10/19/2011	A11SOH.pdf (Superceded)
08/23/2011	Form	Pacific PremierCare Temporary Insurance Agreement (TIA)	10/19/2011	A11TIA.pdf (Superceded)
08/23/2011	Supporting Document	Flesch Certification	10/25/2011	READABILITY CERTIFICATION.pdf (Superceded)
08/23/2011	Supporting Document	Health - Actuarial Justification	10/26/2011	PACLife_ActMemo_Life.pdf (Superceded) PACLife_ActMemo RS.pdf (Superceded)

08/23/2011	Supporting Document	Outline of Coverage	10/19/2011	Outline of Coverage.pdf (Superceded)
08/23/2011	Supporting Document	Supporting Documentation	10/19/2011	A11ARI.pdf (Superceded) A11AUT.pdf A11DIS.pdf LTCLT.pdf M11SLT.pdf M11SPW.pdf (Superceded) N11TYK.pdf N11PHI.pdf M11RPL.pdf

Statement of Variability
Policy Form N11OOC

Location	Factor	Sample Value	Range	Conditions
Page 1	Company contact information	45 Enterprise, Aliso Viejo, CA 92656 (800) 347-7787 www.PacificLife.com	Company address, web site, telephone number	Reflects the current address, web site and phone number of company
Page 4	LTC Benefits Alternative Care Benefit Assisted Living Facility Benefit Caregiver Training Benefit Home and Comm. Care Bene. International Benefit Non-Contin. Alt. Care Benefit Nursing Home Benefit	0 Days 30 Days 0 Days 0 Days 30 Days 0 Days 30 Days	0-90 days The maximum elimination periods will be no greater than the periods listed in the IIPRC Member State Information for Individual Long-Term Care Insurance Uniform Standards chart	May change after an actuarial pricing evaluation. Any such change will apply to new issues

Statement of Variability
Policy Form P11PPC

	Factor	Sample Value	Range	Conditions
Cover	Company contact information	45 Enterprise, Aliso Viejo, CA 92656, www.pacificlife.com, (800) 347-7787.	Company address, web site, telephone number	Reflects the current address, web site and phone number of company
Cover	Officers	James T. Morris Jane M. Guon	Signatures of officers	Reflects the current holders of the titles indicated below the signatures
Cover	Insured	Jane Doe	Insured's name	Owner's choice
Cover	Owner	Leland Stanford	Owner's name	Owner's choice
Cover	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Cover	Policy Date	November 1, 2011	Date policy is in force	Administrative system assigns
Cover	State Department of Insurance Phone Number	STATE (XXX) XXX-XXXX	One of 50 states and D.C. Dept. of Ins. phone number of one of 50 states and D.C.	Administrative system assigns based on state where policy is issued
Cover	Marketing Name	PPC	Marketing abbreviation	Marketing decision
Page 3.0	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 3.0	Extended Benefit Rider	R11EBR Extended Benefit Rider	Present or not present	Owner's choice
Page 3.0	Insured	Jane Doe	Insured's name	Owner's choice
Page 3.0	Owner	Leland Stanford	Owner's name	Owner's choice
Page 3.0	Policy Date	November 1, 2011	Date policy is in force	Administrative system assigns
Page 3.0	Sex and Age	Female 35	Male and Female Issue ages 30-75	Administrative system assigns
Page 3.0	Risk Class	Nonsmoker with Couples Discount	Smoker or Nonsmoker Couples Discount displays only when a couples discount is assigned. It does not display when there is not a couples discount	Underwriter assigns
Page 3.0	Net Amount at Risk Factor	1.0032737	1.001652 to 1.004868	May change after an actuarial pricing evaluation. Any such change will apply to new issues.

Statement of Variability
Policy Form P11PPC

Location	Factor	Sample Value	Range	Conditions
Page 3.0	MEC Status	This Policy is a Modified Endowment Contract	This phrase will display if the policy is a MEC, according to Code Section 7702A. Nothing will display if the policy is not a MEC according to Code Section 7702A	System calculates
Page 3.0	7 Pay Premium	7 Pay Premium $1,416.00	The 7 Pay Premium will display only if the policy is not a MEC. If the policy is a MEC, the 7 Pay Premium will not display	System calculates
Page 3.0	Guaranteed Annual Interest Rate	4.0%	2% to 6% If the GAIR changes within this range, we will submit the change for IIPRC review.	Market conditions may require rate to be adjusted. Any such change will apply to new issues.
Page 3.0	Table of Surrender Charge Factors	Initial Amount - $757.00 Reduction Factor - $151.40	These amounts vary by issue age, gender and risk class	System calculates
Page 3.0	Surrender Charge Periods	Level 5 Years Surrender Charge Period 10 Years	0 to 20 years	May change after an actuarial pricing evaluation. Any such change will apply to new issues.
Page 3.0	Maximum Monthly Coverage Charge	$16.88 $0.00	These amounts vary by issue age, gender and risk class	System calculates
Page 3.1	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 3.1	Face Amount (Life Coverage)	$50,000	Minimum is $50,000 Maximum is $600,000, based on reinsurance	Owner's choice
Page 3.1	Limited Refund on Death		The Limited Refund on Death will be present or not present. It will be present if the premium paid is greater than the Death Proceeds. The following will display on the specifications page: Limited Refund on Death $XX,XXX The Limited Refund on Death will be zero unless the total premium (Life + ABR + EBR) is greater than the policy Death Proceeds. This will typically only apply at older ages	System Calculates

			with one of the inflation options	
Location	**Factor**	**Sample Value**	**Range**	**Conditions**
Page 3.1	Death Proceeds	$50,000	This amount is the total of the Face Amount	System calculates
Page 3.1	Life Coverage	$10,383.00	This is a single premium based on the filed premium rates	System calculates
Page 3.1	Accelerated Benefit Rider (ABR)	$3,143.50	This is a single premium based on the filed premium rates	System calculates
Page 3.1	Extended Benefit Rider (EBR)	$3,520.00	This is a single premium based on the filed premium rates. This amount displays only if the owner applies for the EBR rider	System calculates
Page 3.1	Total Premium	$17,046.50	The sum of Life Coverage and Rider premiums	System calculates
Page 3.1	Return of Premium Benefit	$17,046.50	The total of all premiums	System calculates
Page 3.1	Maximum ABR Benefit Limit	$50,000.00	Maximum amount that can be paid during the entire benefit period. This includes benefits subject to the Maximum Monthly ABR Benefit as well as benefits paid for Caregiver Training, Home Modification or Durable Medical Equipment	System calculates
Page 3.1	Maximum EBR Benefit Limit	4 Years $100,000	1-6 years This includes benefits subject to Maximum Monthly EBR Benefit as well as benefits paid for Caregiver Training, Home Modification or Durable Medical Equipment	Owner's choice Maximum calculated by the system
Page 3.1	Minimum Automatic Inflation Benefit	$11,250.00	This benefit is optional and displays only if the owner applies for this	Owner's choice
Page 3.1	Total Long Term Care Benefit	6 Years	2-8 years	Owner's choice
Page 3.1	Total Long Term Care Benefit	$161,250.00	This is the sum of the benefit amounts listed above this total	System calculates

Statement of Variability
Policy Form P11PPC

Location	Factor	Sample Value	Range	Conditions
Page 3.1	Monthly Maximum ABR[and EBR] Benefit Amount	$2,083.33	EBR displays only if the owner applied for this benefit. If not applied for, the words 'and EBR' will not display. The benefit amount is the result of the ABR Benefit Limit divided by the number of months of the ABR Benefit Duration.	System calculates
Page 3.1	Automatic Inflation Option	Rejected 3% Simple	Displays Rejected if the owner does not apply for this option. If owner applies for this option,one of the following will display: 3% Simple 5% Simple 5% Compound	Owner's choice
Page 3.1	LTC Benefits Alternative Care Benefit Assisted Living Facility Benefit Caregiver Training Benefit Home and Comm. Care Bene. International Benefit Non-Contin. Alt. Care Benefit Nursing Home Benefit	0 Days 30 Days 0 Days 0 Days 30 Days 0 Days 30 Days	0-90 days The maximum elimination periods will be no greater than the periods listed in the IIPRC Member State Information for Individual Long-Term Care Insurance Uniform Standards chart	May change after an actuarial pricing evaluation. Any such change will apply to new issues.
Page 3.1	Non-Continual Alternative Care Benefit Lifetime Maximum Caregiver Training Benefit Lifetime Maxiumum	and EBR	Present or not, depending whether the owner applied for EBR	Administrative system adds
Page 4.0	Policy Number	LTC6999990	Administrative system assigns	Administrative system assigns
Page 4.0	Insured	Jane Doe	Insured's name	Owner's choice
Page 4.0	Table of COI Rates for Life Coverage	2001 CSO Mortality Table	Monthly Rate varies, based upon Risk Class. Note: Guaranteed COI rates based upon 2001 CSO mortality table	System calculates

PACIFIC LIFE

Pacific Life Insurance Company • [45 Enterprise • Aliso Viejo, CA 92656]
[www.PacificLife.com (800) 347-7787]

READ YOUR POLICY CAREFULLY. This is a legal contract between you, the Owner, and us, Pacific Life Insurance Company, a stock insurance company. We agree to pay the benefits of this policy according to its provisions. The consideration for this policy is the Application for it, a copy of which is attached, and payment of the initial premium.

The method for determining the Death Benefit is described in the Death Benefit section of this policy. The amount of the Death Benefit may decrease as a result of withdrawals or paid policy or rider benefits.

Premiums are flexible, subject to minimums required to keep the policy In Force. It is possible that, due to loans against the policy Accumulated Value, the policy may not continue In Force; that is, it may lapse before any Death Benefit is payable on the death of the Insured.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Benefit Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**

Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Number:	[LTC6999990]
Policy Date:	[November 1, 2011]

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Free Look Right – The Owner has 30 days from the day the policy and any riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the policy and riders. The policy and riders can be returned to us at our Administrative Office or to the Producer through whom they were bought. We will refund the full amount of any premium paid within 30 days of such a return and the policy and any riders will be void from the start.

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POLICY SPECIFICATIONS

Summary of Coverages Effective on the Policy Date

P11PPC	Flexible Premium Adjustable Life Insurance (Life Coverage)
R11ABR	Accelerated Benefit Rider (“ABR”) for Long-Term Care
[R11EBR	Extended Benefit Rider (“EBR”) for Long-Term Care]

Life Policy:	Flexible Premium Adjustable Life Insurance
Insured:	[Jane Doe]
Owner:	[Leland Stanford]
Policy Date:	[November 1, 2011]
Sex And Age:	[Female 35]
Risk Class:	[Nonsmoker] [with Couples Discount]
Death Benefit Qualification Test:	Cash Value Accumulation Test
Net Amount at Risk Factor:	[1.0032737]
[This Policy Is a Modified Endowment Contract]	
[7 Pay Premium:	$1,416.00]
Guaranteed Annual Interest Rate:	[4.0%]
Monthly Deduction End Date:	Policy Anniversary When the Insured Attains Age 95
Surrender Charge	
Initial Amount:	[$757.00]
Level Period:	[5] Years
Reduction Factor:	[$151.40]
Surrender Charge Period:	[10] Years
Maximum Monthly Coverage Charge	
Years 1 -10:	[$16.88]
Year 11 +:	[$0.00]

POLICY SPECIFICATIONS

Summary of Values Effective on the Policy Date

Death Proceeds (Before Minimum Death Benefit)	**Benefit Amount**
Face Amount (Life Coverage):	[$50,000.00]
Death Proceeds:	[$50,000.00]

Coverage Type	**Premium Amount**
Life Coverage:	[$10,383.00]
Accelerated Benefit Rider (ABR):	[$3,143.50]
[Extended Benefit Rider (EBR):]	[$3,520.00]
Total Premium:	[$17,046.50]
Return of Premium Benefit:	[$17,046.50]

Long-Term Care Benefit Limits	**Elected Benefit Duration**	**Benefit Amount**
Maximum ABR Benefit Limit:	2 Years	[$50,000.00]
[Maximum EBR Benefit Limit:]	[4 Years]	[$100,000.00]
[Minimum Inflation Benefit Option:]		[11,250.00]
Total Long-Term Care Benefit:	[6 Years]	[$161,250.00]
Monthly Maximum ABR [and EBR] Benefit Amount:		[$2,083.33]
Inflation Benefit Option for ABR [and EBR]:		[Rejected] [3% Simple]

Long-Term Care Benefits	**Elimination Period**
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[30] Days
Care Coordination Benefit:	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[30] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[30] Days

Non-Continual Alternative Care Benefit Lifetime Maximum – Lesser of $5,000 or Monthly Maximum ABR Benefit Amount at time of policy issue while covered under ABR [and EBR].

Caregiver Training Benefit Lifetime Maximum – $1,000 for the Caregiver Training Benefit while covered under ABR [and EBR].

For questions about your policy or to discuss policy and rider benefits, you may contact us at our Administrative Office at (800) 347-7787or at www.PacificLife.com.

POLICY SPECIFICATIONS

TABLE OF COST OF INSURANCE RATES

FOR LIFE COVERAGE

INSURED: [JANE DOE]

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

POLICY YEAR	MONTHLY RATE	POLICY YEAR	MONTHLY RATE
[1	0.07670	45	3.43850
2	0.08250	46	3.82530
3	0.08750	47	4.30290
4	0.09170	48	4.81110
5	0.09670	49	5.34790
6	0.10260	50	5.95010
7	0.10920	51	6.56440
8	0.11670	52	7.29570
9	0.12590	53	8.20720
10	0.13680	54	9.17860
11	0.14930	55	10.15600
12	0.16430	56	10.88250
13	0.18180	57	11.58260
14	0.20110	58	12.75540
15	0.22280	59	14.36970
16	0.24700	60	16.42160
17	0.27460	61+	0.00000]
18	0.30550		
19	0.33810		
20	0.37240		
21	0.41180		
22	0.45450		
23	0.49970		
24	0.54660		
25	0.59440		
26	0.64480		
27	0.70020		
28	0.75900		
29	0.82120		
30	0.88930		
31	0.96510		
32	1.04770		
33	1.13960		
34	1.24180		
35	1.35340		
36	1.47950		
37	1.62360		
38	1.78150		
39	1.95420		
40	2.14600		
41	2.35700		
42	2.58910		
43	2.84660		
44	3.12830		

DEFINITIONS

In this section, we define certain terms used throughout this policy. Other terms may be defined in other parts of the policy. Defined terms are usually capitalized to provide emphasis.

Accumulated Value – is the sum of Net Premiums and credited interest less withdrawals, monthly deductions, and any reductions due to the Terminal Illness Benefit Payment or benefit payments under a rider. See the Accumulated Value and Policy Loan sections for details.

Administrative Office – is the office that administers your policy. The mailing address of the Administrative Office at the time you applied for this policy is shown in the heading of the Application. If the address changes, we will send you written notice of the new address.

Age – means the age as of the Insured's birthday prior to the Policy Date, increased by the number of complete policy years elapsed.

Application – consists of the application for this policy, including any Statement of Good Health and Insurability, amendments, endorsements, and any application for reinstatement.

Class – is used in determining policy charges and interest credited, and depends on a number of factors, including (but not limited to) the Death Benefit, Face Amount, Policy Date, policy duration, the Insured's Age and Risk Class and the presence of optional riders and benefits.

Code – is the U.S. Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

Evidence of Insurability – is information, including medical information, that is used to determine insurability and the Insured's Risk Class, subject to our approval.

Face Amount – is the Face Amount of Life Coverage as shown in the Policy Specifications.

Insured – is the person insured under this policy, as shown in the Policy Specifications.

In Force – means a policy is in effect and provides a Death Benefit or Residual Death Benefit on the Insured.

Life Coverage – is insurance coverage on the Insured provided by this policy as shown in the Policy Specifications, rather than coverage provided by rider.

Monthly Deduction End Date – is shown in the Policy Specifications and is the date when Monthly Deductions end.

Monthly Payment Date – is the same day in each month as the Policy Date and is the date on which certain policy charges are deducted from the Accumulated Value. The first Monthly Payment Date is the Policy Date.

Net Accumulated Value – is the Accumulated Value less any Policy Debt.

Net Amount at Risk – is the difference between the Death Benefit and the Accumulated Value.

Net Premium – is the premium we receive for Life Coverage.

Owner, you, or your – refers to the Owner of this policy.

Policy Date – is shown in the Policy Specifications and means the date the policy and associated riders become effective. Policy and rider months, quarters, years and anniversaries are measured from this date.

Policy Debt – is the sum of the Loan Account and accrued Loan Interest charged.

Policy Specifications – is a section of the policy that shows information specific to your policy.

Risk Class – is used in determining policy charges and is determined by us during the underwriting process. Risk Class depends on the Insured's gender, health, tobacco use, and other factors. The Risk Class of the Insured is shown in the Policy Specifications. Risk Class may also be referred to as Risk Classification.

We, our, ours, and us – refers to Pacific Life Insurance Company.

Written Request – is your signed request in writing, or on a form we provide, and received by us at our Administrative Office, containing information we need to act on the request.

DEATH BENEFIT

When the Policy is In Force – This policy is In Force as of the Policy Date, subject to your acceptance of the delivered policy and payment of the initial premium. The policy remains In Force until the earliest of the following:

- Surrender, as described in the Surrender and Withdrawal of Values section;
- Lapse, as described in the Policy Lapse and Reinstatement section; or
- The death of the Insured.

Coverage under this policy will be reduced by any decreases in Face Amount, as described in later sections of this policy or riders attached to this policy.

Death Benefit – This policy provides a Death Benefit on the death of the Insured while this policy is In Force. This section describes how the Death Benefit is calculated. The Death Benefit is the larger of:

- The Face Amount reflecting any reductions as a result of withdrawals, any Terminal Illness Benefit Payment, or any rider benefits paid; or
- The Minimum Death Benefit according to the Cash Value Accumulation Test.

The Death Benefit as calculated above is subject to any increase required by the minimum death benefit provisions set out in General Provisions to satisfy certain federal tax qualification requirements.

Death Benefit Qualification Test – In order for your policy to qualify as a life insurance contract under the Code, it must at all relevant times satisfy the Cash Value Accumulation Test. The policy provides a Minimum Death Benefit amount, as needed, for the policy to qualify under the Cash Value Accumulation Test.

Minimum Death Benefit – The Minimum Death Benefit at any time will be the minimum amount required for this policy to qualify as a life insurance contract under the Code, but not less than 101% of the greater of the Accumulated Value or the Life Return of Premium Benefit.

Death Proceeds – The Death Proceeds ("Proceeds") amount is the actual amount payable to the beneficiary if the Insured dies while this policy is In Force. The Proceeds amount is equal to the greater of the Death Benefit or the Residual Death Benefit, as of the date of death:

- Less any Policy Debt; and
- Less any Monthly Deductions that may be due and unpaid if death occurs during a Grace Period.

Proceeds paid are subject to the conditions and adjustments defined in other policy provisions, such as General Provisions, withdrawals, Policy Loans, and Timing of Payments. We will pay interest on the Proceeds from the date of death at a rate not less than the rate payable for funds left on deposit (see the Income Benefits section). If payment of Proceeds is delayed more than 31 calendar days after we

receive the following requirements needed to pay the claim, we will pay additional interest at a rate of 10% annually beginning with the 31st calendar day referenced above. Proceeds are paid as a lump sum unless you choose to have the Proceeds paid under an income benefit plan available on the date of election, subject to our requirements.

We will pay the Proceeds to the beneficiary after we receive, at our Administrative Office:

- Due proof of the Insured's death, consisting of a certified copy of the death certificate for the Insured or other lawful evidence providing equivalent information;
- Proof of the claimant's legal interest in the Proceeds; and
- Sufficient evidence that any legal impediments to payment of Proceeds that depend on parties other than us have been resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; (c) submission of information required to satisfy state and federal reporting requirements; and (d) conflicting claims.

Residual Death Benefit – This policy provides a Residual Death Benefit if greater than the Death Benefit, in an amount equal to the lesser of 5% of the initial Face Amount, as shown on the Policy Specifications, or $5,000.00. Any withdrawals and any Terminal Illness Benefit Payment will reduce the Residual Death Benefit in the same proportion that they reduce the Face Amount.

Face Amount Changes – A requested increase or decrease in Face Amount is not allowed.

Face Amount Decreases – A decrease in Face Amount will occur as a result of:

- Withdrawals of policy Accumulated Value; or
- Rider benefits or Terminal Illness Benefit exercised while the policy is In Force.

The effective date of the decreased Face Amount will be the date we have processed the withdrawal, rider benefit, or Terminal Illness Benefit. Upon processing any decrease, we will send you written notification reflecting the decrease.

Change in Benefits – Under the Cash Value Accumulation Test, any change in policy or rider benefits or certain other factors may require an adjustment to the policy's tax qualification limits.

PREMIUMS

Premiums – The initial premium is payable either at our Administrative Office or to our authorized representative before we can place your policy In Force. At your request, we will give you a premium receipt signed by one of our officers. Additional premiums are optional and are payable at any time at our Administrative Office. We will consider any premium paid after the initial premium, whether delivered to an independent producer or otherwise, to be "received" when it is actually delivered to our Administrative Office. Except for the initial premium, we bear no responsibility for any premium unless we have received the premium. We reserve the right to reject premium payments less than $50 unless such premium is required to keep the policy In Force. Premiums may be paid at any time before the Monthly Deduction End Date, subject to the premium limits below. Any payment we receive from you while you have a loan will be first considered a loan repayment, unless you tell us by Written Request it is a premium payment.

Premium Processing – When a premium is received by us, the Net Premium will be credited to the Accumulated Value.

Premium Limitation – We reserve the right to require Evidence of Insurability satisfactory to us for any premium payment that would result in an increase in the Net Amount at Risk and, if such Evidence of Insurability is not satisfactory, to limit or refuse the premium payment, unless it is necessary to keep the policy In Force.

Modified Endowment Contract Premium Limit – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract under Section 7702A of the Code as of the Policy Date. Otherwise, in order that this policy not be classified as a Modified Endowment Contract under Section 7702A of the Code, the sum of premiums paid less a portion of any withdrawals may not exceed the 7-Pay limit as defined in the Code. The 7-Pay limit is the cumulative sum of the 7-Pay Premiums during the applicable 7-Pay testing period. In the event that a premium payment would cause the 7-Pay limit to be exceeded, we will refund the excess payment to you, unless you have provided a Written Request in which you accept your policy being classified as a Modified Endowment Contract and indicate that we may accept such payments and apply them to the policy, in accordance with the Modified Endowment Contract Tax Status subsection of this policy.

The 7-Pay Premium may change whenever there is a change in the Face Amount of insurance or in other policy benefits or factors. The 7-Pay Premiums are determined according to the rules applicable to this policy set forth in the Code. The 7-Pay Premium will be adjusted to conform to any changes in the Code. To the extent that a premium payment would cause such limits to be exceeded, we will refund the excess payment to you, in accordance with the Modified Endowment Contract Tax Status section of this policy. Further, as indicated in that section, we will increase the Death Benefit to the extent we deem necessary to continue to classify this policy as a non-Modified Endowment Contract under the Code.

TERMINAL ILLNESS BENEFIT

Terminal Illness Benefit – If the Insured has been diagnosed with a terminal illness, you have the option to receive a portion of the Face Amount while the Insured is still living. This is called a Terminal Illness Benefit. A "terminal illness" means an illness causing the Insured to have a life expectancy of 12 months or less.

Eligible Coverage – is the portion of the Face Amount that will qualify for determining the Terminal Illness Benefit at the time the benefit is exercised. Eligible Coverage is the policy Face Amount less any reductions as a result of withdrawals or paid rider benefits on the policy.

Requested Portion – is the amount of the Face Amount you request in a Written Request on a form provided by us. The Requested Portion cannot exceed the lesser of 75% of the Eligible Coverage or $500,000.

Requested Percentage – is the Requested Portion divided by the Eligible Coverage.

Terminal Illness Benefit Payment – is the actual dollar amount of benefit you will receive as a Terminal Illness Benefit. The Terminal Illness Benefit Payment will be determined as of the date we approve your Written Request for a Terminal Illness Benefit. Your Terminal Illness Benefit Payment will equal your Requested Portion less the following adjustments:

a) A reduction rate will be applied to the Requested Portion, and reflects the early payment of the Requested Portion of your policy. The reduction rate will be based on the12 month life expectancy of the insured at an annual interest rate declared by us. The reduction rate shall be no greater than the greater of the following rates in effect on the date of your written request for a Terminal Illness Benefit:
    i) the yield on 90-day treasury bills; or
    ii) the maximum statutory adjustable policy loan interest rate.

b) If there is a Policy Loan on your policy as of the date we approve your Written Request, we will reduce the Requested Portion in order to repay a portion of the Policy Loan equal to the Requested Percentage times the outstanding loan.

c) A processing charge deducted from the Terminal Illness Benefit, not to exceed $150.

We will refund the amounts discussed in a) and c) above should the death of the Insured occur within 30 days of the Terminal Illness Benefit Payment.

The Terminal Illness Benefit Payment will be paid as a lump sum. The minimum Terminal Illness Benefit Payment amount is $500. We place no restrictions on how you use any Terminal Illness Benefit that may be paid under this provision. We will pay the Terminal Illness Benefit amount only once per Insured, even if such person may be insured under more than one policy with us.

This Terminal Illness Benefit is not meant to cause involuntary access to proceeds payable to the beneficiary on the death of the Insured. Therefore, this benefit is not available if either you or the Insured:

a) is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or

b) is required by a government agency to use this benefit in order to apply for, obtain or keep a government benefit or entitlement.

Effect of Terminal Illness Benefit Payment on Policy and Riders – After a Terminal Illness Benefit Payment is made, the policy and riders will remain In Force subject to the following adjustments. The Face Amount, Coverage Charge, and any Accumulated Value will be reduced by the Requested Percentage. The Return of Premium Benefit will be reduced by the Requested Portion corresponding to the Terminal Illness Benefit Payment amount paid. Any outstanding Policy Loan balance will be reduced as specified in the Terminal Illness Benefit Payment Section. Cost of Insurance Charges will be adjusted to reflect the reduction in the Death Benefit. A statement demonstrating how the Terminal Illness Benefit impacts your policy values will be sent with the Terminal Illness Benefit Payment.

Eligibility – The following conditions must be met before any Terminal Illness Benefit Payment is made:

- The policy must be In Force on the date the Terminal Illness Benefit Payment is approved;
- We must receive written proof that the life expectancy of the Insured is 12 months or less from the date of the Written Request. Proof will include the certification by a licensed physician. Such person may not be you or a member of your family. Such proof should include clinical, radiological or laboratory evidence of the condition. We reserve the right to obtain a second medical opinion from a physician of our choice at our expense. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion, at our expense, that is provided by a physician that is acceptable to you and to us.
- The owner or legal guardian must make the Written Request.

Expiration Date – Your right to exercise the Terminal Illness Benefit will end when the policy is no longer In Force, when the Accumulated Value is zero, or when a Terminal Illness Benefit is paid.

Disclosure – The following should be taken into consideration before you exercise your option to receive the Terminal Illness Benefit:

- Policy Death Benefits, Coverage Charge, Accumulated Value, and Cash Surrender Value will be reduced if a Terminal Illness Benefit is paid;
- This Terminal Illness Benefit is NOT health, nursing home or long-term care insurance, and it is not intended or designed to eliminate the need for such coverage;
- Receipt of the Terminal Illness Benefit Payment may affect Medicaid, Medicare, and/or Supplemental Security Income (SSI) eligibility. Exercising the option to accelerate and receive benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility.

ACCUMULATED VALUE

Accumulated Value – The Accumulated Value equals the sum of:

- Fixed Accumulated Value; and
- Loan Account Value, as described in the Policy Loans section.

Fixed Accumulated Value – On the Policy Date, the Fixed Accumulated Value equals the Net Premium received less the first Monthly Deduction. On each other day, the Fixed Accumulated Value equals:

- The Fixed Accumulated Value as of the prior day;
- Plus interest earned on such amount since the prior day;
- Plus the amount of any Net Premiums received since the prior day;
- Less the amount of any withdrawal since the prior day;
- Less the amount of any Policy Loan, including any Policy Loan to pay Policy Loan interest, taken since the prior day;
- Less reduction for benefits paid since the prior day as described in the riders attached to this policy;
- Less reduction for the Requested Portion for any Terminal Illness Benefit Payment since the prior day as described in the Terminal Illness Benefit section;
- Plus the amount of any loan repayment made since the prior day; and
- Less, on a Monthly Payment Date, the Monthly Deduction.

We credit interest to the Fixed Accumulated Value on a daily basis at the end of each day, using a 365-day year, at a rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. At our discretion, we may credit additional interest. Any such additional interest may be adjusted to reflect expenses, taxes, profit, or sources of earnings other than investment earnings and will be applied uniformly to all members of the same Class. Once credited, the additional interest is nonforfeitable except indirectly due to the Surrender Charge.

POLICY CHARGES

Monthly Deduction – The Monthly Deduction provides coverage for the policy month following the Monthly Payment Date and is deducted from the Accumulated Value on each such date before the Monthly Deduction End Date. It is equal to the sum of the following items:

- The Cost of Insurance Charge;
- The Coverage Charge; and
- Rider charges, if any.

The maximum for each such charge is described below or in the rider forms. We may charge less than such maximum charge. Any lesser charge will apply uniformly to all members of the same Class.

Coverage Charge – This charge is based on the Face Amount of the policy and will not exceed the Maximum Monthly Coverage Charge shown in the Policy Specifications. The Coverage Charge will decrease proportionately to the Face Amount Decrease as a result of a withdrawal or payment of a Terminal Illness or rider benefit.

Rider Charges – Any rider charges are described in the rider.

Cost of Insurance Charge – The Cost of Insurance Charge is equal to (1) multiplied by (2), where:
(1) is the Monthly Cost of Insurance Rate divided by 1000 as shown in the Policy Specifications; and
(2) is the Death Benefit divided by the Net Amount at Risk Factor shown in the Policy Specifications, reduced by the Accumulated Value as of the beginning of the policy month before the Monthly Deduction is assessed.

Cost of Insurance Rates – The Maximum Monthly Cost of Insurance Rates for the initial Life Coverage are shown in the Policy Specifications.

POLICY LAPSE AND REINSTATEMENT

Grace Period – If the Accumulated Value less Policy Debt on a Monthly Payment Date is sufficient to cover the Monthly Deduction due, the policy will continue In Force. If the Accumulated Value less Policy Debt on a Monthly Payment Date is not sufficient to cover the Monthly Deduction due, a Grace Period of 61 days will be allowed for the payment of sufficient loan repayment or premium to keep your policy In Force. The Grace Period begins on the Monthly Payment Date on which the insufficiency occurred and ends 61 days thereafter. At the start of the Grace Period, we will provide a Grace Notice to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. There is no penalty for paying a premium during the Grace Period. Your policy will remain In Force during the Grace Period.

Notification of Termination for Non-Payment – Thirty days after the Monthly Payment Date on which the insufficiency occurred, we will provide a notification of termination for non-payment to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. The notice will be provided to each person at their last known addresses by first class United States mail, postage prepaid and will state the due date and the amount of loan repayment or premium required for your policy to remain In Force. A minimum of the monthly charges not deducted plus three times the monthly deduction due when the insufficiency occurred must be paid.

Lapse – If sufficient loan repayment or premium is not paid by the end of the Grace Period, a lapse will occur. If the Insured dies during the Grace Period, the Death Proceeds will be equal to the Death Proceeds as of the beginning of the Grace Period reduced by any overdue charges. Upon lapse, the policy will terminate with no value.

Reinstatement – If it has not been surrendered, this policy may be reinstated within five years after the end of the Grace Period. To reinstate this policy you must provide us with the following:

- A written application;
- Full repayment of Policy Debt, if a loan was outstanding at the time of lapse;
- Evidence of Insurability satisfactory to us; and
- Sufficient premium to cover all Monthly Deductions and Loan Interest Charges due and unpaid during the Grace Period.

The effective date of the policy reinstatement will be the Monthly Payment Date on or next following the date we approve your reinstatement application. Upon reinstatement:

- The Accumulated Value will equal the amount it was at the beginning of the Grace Period, plus the reinstatement Net Premium, less Monthly Deductions as indicated below (including those due and unpaid during the Grace Period);
- The Surrender Charges and policy charges (other than Cost of Insurance Charges) for Life Coverage under this policy will resume on their schedule as of the Monthly Payment Date when lapse occurred;
- Cost of Insurance Charges will be calculated using Cost of Insurance Rates that resume their original schedule as if lapse had never occurred, reflecting the Insured's Age at reinstatement and policy duration measured from the original Policy Date; and
- The periods during which we may exclude death by suicide and contest coverage due to a material misstatement in the reinstatement application will begin from the reinstatement date.

After the reinstatement premium has been applied, regular policy processing of Monthly Deductions will occur for the period of time when coverage was provided during the Grace Period. There will be no Monthly Deductions between the time of lapse and reinstatement.

SURRENDER AND WITHDRAWAL OF VALUES

Surrender – Upon Written Request while the policy is In Force, you may surrender this policy for its Net Cash Surrender Value. If surrendered within 30 days following a policy anniversary, the value available shall not be less than the anniversary value, less any withdrawal, Policy Loan, Terminal Illness Benefit Payment, or rider benefit paid since the policy anniversary. If surrendered at any time other than on a policy anniversary, the value available shall be calculated with allowance for lapse of time from the last preceding policy anniversary. The policy will terminate on the date the Written Request is received at our Administrative Office. The policy cannot be surrendered during the Grace Period.

Net Cash Surrender Value – The Net Cash Surrender Value is the Cash Surrender Value less any Policy Debt.

Life Return of Premium Benefit – The Life Return of Premium Benefit is equal to the Life Coverage Premium Amount at issue, as shown in the Policy Specifications.

Return of Premium Benefit – The Return of Premium Benefit is not available if your policy was issued upon the exercise of a conversion option from another policy. Otherwise, the Return of Premium Benefit, if greater than the Accumulation Value less any Surrender Charge, is available upon surrender of the policy. The Return of Premium Benefit is equal to the sum of the Life Return of Premium Benefit and any Return of Premium Benefit under riders attached to the policy. There are no increases to the Return of Premium Benefit after issue, even if additional premiums are paid.

After issue, the Return of Premium Benefit is reduced by the following events:

- Any withdrawals;
- The Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy; and
- Any benefit payments made under the riders.

These events will reduce the Life Return of Premium Benefit first (but not below zero), and then any Return of Premium Benefit under riders attached to the policy.

Cash Surrender Value – The Cash Surrender Value is equal to the greater of:

- The Accumulated Value less any Surrender Charge; or
- The Return of Premium Benefit.

Surrender Charge – If you surrender this policy, there may be a Surrender Charge deducted from the Accumulated Value. During the Level Period, the Surrender Charge is equal to the Initial Amount. After the Level Period, the Surrender Charge decreases by the Reduction Factor for the remaining Surrender Charge Period. The Initial Amount, Level Period, Reduction Factor and Surrender Charge Period are shown in the Policy Specifications.

Withdrawals – Upon Written Request on or after the first policy anniversary, you may withdraw a portion of the Net Cash Surrender Value of this policy. Such withdrawal will be deducted from the Accumulated Value. There is no Surrender Charge imposed for a withdrawal, even if the Face Amount is reduced as a result of the withdrawal. Withdrawals may be restricted or prohibited by certain riders attached to the policy. Withdrawals will be subject to the following conditions:

- The amount of each withdrawal must be at least $200;
- The Net Accumulated Value less any Surrender Charge remaining after a withdrawal must be at least $500; and
- The Face Amount remaining after the withdrawal must be at least $50,000.

A withdrawal will reduce the Face Amount in proportion to the amount of the withdrawal divided by the Accumulation Value before the withdrawal. If such a reduction in Face Amount would cause the policy to become a Modified Endowment Contract, we will not process your withdrawal request unless and until we

receive your Written Request to have your policy classified as a Modified Endowment Contract. Refer to the Premiums section for details.

If the Insured dies after the request for a withdrawal is received by us and prior to the withdrawal being processed, the withdrawal, if allowed under this provision, will be processed and paid to the owner, or to the owner's estate, before the Death Proceeds are determined and paid to the beneficiary.

INCOME BENEFITS

Income Benefits – All or part of any policy proceeds may, instead of being paid in a lump sum, be left with us under any one, or a combination of the income benefit plans available, subject to our minimum amount requirements on the date of election. If the payee is not a natural person, the choice of a payment option will be subject to our approval. We guarantee that the income benefit will not be less than the income that would be provided by the immediate annuity purchase rates we offer at the time. We guarantee that we will have at least the following income benefit plans available.

Fixed Income – Equal payments of the amount chosen with interest of not less than 2% per year until the funds left on deposit are exhausted.

Life Income – Monthly income will automatically be guaranteed to continue for at least ten years. If the payee dies before the end of the ten-year period, payments will continue to the end of the ten-year period to a person designated in writing by that payee. The purchase rates for the monthly income for a male or female income recipient bought by each $1,000 of benefits are shown below.

Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income	Age	Monthly Income
0-30	2.38	40	2.63	50	3.00	60	3.60	70	4.63
32	2.42	42	2.69	52	3.10	62	3.76	72	4.92
34	2.47	44	2.76	54	3.20	64	3.94	74	5.26
36	2.52	46	2.83	56	3.32	66	4.14	75+	5.45
38	2.57	48	2.91	58	3.45	68	4.37		

Monthly income amounts for ages not shown are halfway between the two amounts for the nearest two ages that are shown. Amounts shown are based on an annual interest rate of 2% and the Annuity 2000 female mortality table with five-year age setback. We may require evidence of survival for incomes that last more than ten years.

POLICY LOANS

Policy Loans – You may obtain policy loans by Written Request after the Free Look Period, on the sole security of the Loan Account of this policy. We recommend you consult your tax advisor before requesting a policy loan.

Loan Amount Available – The amount of the loan must be at least $200. The maximum amount available for a loan on any date is equal to the Accumulated Value less:

- Three times the most recent Monthly Deduction;
- Any Surrender Charge; and
- Any existing Policy Debt.

Loan Account – The amount of any Policy Loan will be added to the Loan Account.

Loan Repayment – You may make loan repayments at any time prior to lapse of this policy. Any payment we receive from you while you have a loan will be treated as a loan repayment, unless you tell us by Written Request that it is a premium payment.

Loan Interest Charge – Interest will accrue daily based on the balance in the Loan Account and will be due on each policy anniversary. Such interest is calculated using the simple interest method and is based on the balance in the Loan Account, using an annual interest rate of 5.50%. The corresponding daily interest rate is equal to the annual rate divided by 365. If the policy terminates before a policy anniversary, the Loan Interest Charge will be due at such time.

Policy Debt – The Policy Debt is the amount necessary to repay the Policy Loan in full and is equal to the Loan Account plus any Loan Interest Charge. The Policy Debt reduces any amount otherwise payable under the policy.

Loan Account Value – The Loan Account Value is a portion of the Accumulated Value set aside to secure the Policy Debt. The Loan Account Value is equal to the Loan Account plus Loan Interest. Such interest is based on the balance in the Loan Account, and accrues daily on a simple interest basis, using the Loan Account Interest rate, which is an annual interest rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. The corresponding daily interest rate is equal to the annual rate divided by 365.

Loan Processing on Policy Anniversary – On each policy anniversary we will adjust the values of the Policy Debt, Loan Account and Loan Account Value so that they are equal to each other. To do this, we calculate the difference between the Policy Debt and the Loan Account Value. If the Policy Debt is greater than the Loan Account Value, which is generally the case when the policy loan interest has not been paid, a new loan will be taken for the excess and will be added to the Loan Account. If the Loan Account Value is greater than the Policy Debt, which is generally the case when the policy loan interest has been paid, the excess will be transferred into the Fixed Accumulated Value.

OWNER AND BENEFICIARY

Owner – The Owner of this policy is as shown in the Policy Specifications or as later changed by Written Request. If you change the Owner, the change is effective on the date the Written Request is signed, subject to our receipt of it and subject to any action taken or payment made by us prior to its receipt. If there are two or more Owners, they will own this contract as joint tenants with right of survivorship, unless otherwise provided by Written Request. We recommend you consult your tax advisor before requesting a change of Owner.

Assignment – You may assign this policy by Written Request. An assignment must be recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of any assignment. We recommend you consult your tax advisor before requesting an assignment.

Beneficiary – The beneficiary is named by you in the Application to receive the Death Proceeds. You may name one or more beneficiaries. If you name more than one beneficiary, they will share the Death Proceeds equally or as you may otherwise specify by Written Request. If you have named a contingent beneficiary, that person becomes the beneficiary if the beneficiary dies before the Insured. A beneficiary may not, on or after the Insured's death, assign, transfer or encumber any benefit payable. To the extent allowed by law, policy benefits will not be subject to the claims of any creditor of any beneficiary.

You may make a change of beneficiary by Written Request on a form provided by us while the policy is In Force. The change will take place as of the date the request is signed. Any rights created by the change will be subject to any payments made or actions taken by us before we have received the Written Request.

The interest of a beneficiary who does not outlive the Insured will be divided pro rata among the surviving beneficiaries. If no beneficiaries survive to receive payment, the death proceeds will pass to the Owner, or the Owner's estate if the Owner does not survive the Insured. In the event of a simultaneous death of the Insured and a beneficiary such that it cannot be determined who died first, it will be assumed, unless proof to the contrary is provided, that the beneficiary died last.

GENERAL PROVISIONS

Entire Contract – This policy is a contract between you and us. This policy, the attached copy of the initial Application, including any amendments and endorsements to the Application, any applications for reinstatement, any endorsements, benefits, or riders, and all additional policy information sections added to this policy are the entire contract. Only our president, chief executive officer or secretary is authorized to change this contract or extend the time for paying premiums. Any such change must be in writing.

All statements in the Application shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or defend a claim on grounds of misrepresentation unless the statement is in an Application.

Incontestability – We will not contest this policy unless there was a material misrepresentation in the Application. We will rescind the policy if:

- The policy has been In Force for less than six months and we determine that the Application contains a misrepresentation that is material to acceptance for coverage; and
- The policy has been In Force for at least six months but less than two years and we determine that the Application contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy, we will return to you the premiums paid less any policy loans, any withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. No Death Benefit will be paid. This policy cannot be contested, except as provided below, after it has been In Force for two years during the Insured's lifetime.

If this policy lapses and is later reinstated, we will rescind the policy as of the reinstatement date if:

- Less than six months after the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the reinstatement date but less than two years from the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy following reinstatement, we will return to you the premiums paid after the reinstatement date less any policy loans and any withdrawals taken after the reinstatement date. No Death Benefit will be paid. We will not contest the reinstated policy after it has been In Force for two years following such reinstatement during the Insured's lifetime.

If there has been a change to the policy for which we required the Insured to submit Evidence of Insurability, we will rescind the policy change and all policy charges made after the change will be reversed and corrected charges applied so that the policy's Accumulated Value will be unaffected by the change if:

- Less than six months after the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the change but less than two years from the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

Any Death Benefits or other benefits that become payable will be determined as though the policy change had never been requested. We will not contest any such change after two years following the effective date of the change during the Insured's lifetime.

Non-Participating – This policy will not share in any of our surplus earnings.

Suicide Exclusion – If the Insured dies by suicide, while sane or insane, within two years of the Policy Date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid, less the sum of any policy loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. If this policy has been reinstated and the Insured dies by suicide, while sane or insane, within two years of the latest reinstatement date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid less the sum of any policy loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy since such date.

Misstatement – If the Insured's sex or birth date is misstated in the Application and it is discovered on or after the death of the Insured, the Death Benefit shall be the minimum Death Benefit for the correct sex and birth date, or if greater, a Death Benefit based on a Net Amount at Risk adjusted by the ratio of the incorrect Cost of Insurance Rate to the correct Cost of Insurance Rate. The adjusted Net Amount at Risk will result in an adjusted Death Benefit, since the Death Benefit depends on the Net Amount at Risk.

If the Insured's sex or birth date is misstated in the Application and it is discovered before the death of the Insured, we will recalculate the Accumulated Value using the correct sex and birth date of the Insured.

Maturity – This policy does not mature, but will continue In Force so long as the Insured is alive and the policy has not been surrendered and lapse has not occurred.

After the Monthly Deduction End Date – Provided the policy is still In Force, coverage will continue on and after the Monthly Deduction End Date, subject to all policy provisions, with these exceptions and clarifications:

- Monthly Deductions will cease;
- Premiums will not be accepted, except amounts required to keep the policy in force;
- Loans will be allowed;
- Loan repayments will be permitted;
- Loan interest will continue to accrue; and
- Withdrawals will not be allowed.

Timing of Payments – We may defer payments of any Net Cash Surrender Value, withdrawal or loan (except for loans to pay a premium on any policy issued by us) for up to six months after we receive your request. If we defer any such payment for more than 30 days after we receive your request, we will pay interest at the rate required by the state in which this policy is delivered, and such rate will be at least equal to the Guaranteed Annual Interest Rate shown in the Policy Specifications.

Annual Report – A report will be mailed to your last known address no less frequently than annually. This report will show:

- The beginning and end dates of the reporting period;
- The Accumulated Value at the beginning and end of the reporting period;
- Amounts that have been credited or debited to the Accumulated Value during the reporting period, identified by type;
- The Death Benefit at the end of the reporting period;
- The Net Cash Surrender Value at the end of the reporting period;
- A notice if the Net Cash Surrender Value will not be sufficient to keep the policy in force until the end of the next reporting period, unless further premium payments are made;
- Any Policy Debt outstanding at the end of the reporting period; and
- Any other information required by law.

Additional Report – Each year, you may request, without charge, an additional report showing the same information as the Annual Report.

Basis of Values – All nonforfeiture values for this policy will be at least equal to the minimums required by the state in which this policy was delivered. Cash Values and nonforfeiture benefits available under

this policy are not less than the minimum values and benefits required by or pursuant to the law of the state where the policy was delivered. To calculate the minimum required nonforfeiture values, we use the Guaranteed Annual Interest Rate shown in the Policy Specifications and mortality rates from the 2001 CSO mortality tables using age last birthday. The rates we use are both smoker and sex distinct.

Tax Qualification as Life Insurance – This policy is intended to qualify as a life insurance contract for federal tax purposes, and the Death Benefit under this policy is intended to qualify for federal income tax exclusion. The policy, including any rider, benefit or endorsement that does not specifically override this tax qualification provision, shall be interpreted to ensure and maintain such tax qualification, despite any other provision to the contrary. At no time shall the amount of Death Benefit under this policy ever be less than the minimum amount needed to ensure or maintain such tax qualification. If need be, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary to accomplish that purpose. In addition, the Accumulated Value will be reduced to reflect the increased Monthly Deductions that result from such Death Benefit increase(s), starting on the date that each increase is effective. **As of the effective date of the filing of this policy in the state in which it was delivered, the Internal Revenue Service has not published final guidance on all aspects of the tax treatment of life insurance policies that continue coverage beyond Age 100. You should consult your tax advisor, as there may be tax consequences**.

If you request a withdrawal that causes a decrease in policy or rider benefits, it may cause a reduction in any applicable tax limits on premiums or Accumulated Value for the policy to maintain such tax qualification. Such a reduction in these limits may require us to make a distribution from the policy equal to the greatest amount by which the premiums paid or Accumulated Value for the policy exceed any such reduced limits, as determined under federal tax law, in order to maintain the policy's tax qualification. If such a distribution is made, the distribution will be paid to you and the Accumulated Value will be reduced by the amount of the distribution. However, no request for a withdrawal that causes a decrease in policy or rider benefits will be allowed to the extent that we determine that the resulting reduction in such tax limits would require us to distribute more than the Net Cash Surrender Value for the policy.

Modified Endowment Contract Tax Status – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract ("MEC") as of the Policy Date. If, at the time your policy is issued, we have classified it as a MEC, this will be indicated on the Policy Specifications. Otherwise, unless and until you have given us a Written Request to accept a MEC classification for your policy, the provisions of this Modified Endowment Contract Tax Status subsection apply to your policy.

Under federal tax law, if the funding of a life insurance contract occurs too rapidly, it becomes a MEC and fails to qualify for certain favorable tax treatment as a result. This policy is intended to qualify as a life insurance contract that is not a MEC for federal tax purposes. To achieve these purposes, the provisions of this policy (including any rider or endorsement that does not specifically override this tax qualification provision) shall be interpreted to prevent this policy from being subject to such MEC treatment, despite any other provision to the contrary. If and while the provisions of this subsection apply to your policy, the amount of Death Benefit under this policy shall never be less than the minimum amount needed to avoid such MEC treatment.

We will not accept a payment as premium or otherwise which would cause the policy to become a MEC. The 7-Pay Premium, shown on Page 3.0, is used solely to determine the policy's premium limits to avoid MEC treatment. Payment of one or more 7-Pay Premium amounts does not guarantee that the policy will never lapse, and additional premiums may be necessary to prevent the policy from lapsing in the future.

If at any time the amounts paid under the policy exceed the limit for avoiding such MEC treatment, this excess amount, including any interest as determined under federal tax law, shall be removed from the policy as of the date of its payment, and any appropriate adjustment in the Death Benefit and/or Accumulated Value shall be made as of such date. This excess amount, including any interest, shall be refunded no later than 60 days after the end of the applicable contract year, as determined under federal tax law.

If this excess amount is not refunded by the end of such 60-day period, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary (e.g., to the end of any MEC 7-year test period) so that at no time is the Death Benefit ever less than the minimum amount necessary to avoid Modified Endowment Contract classification. In addition, the Accumulated Value will be reduced to reflect any increased Monthly Deductions resulting from such Death Benefit increase, starting on the date that the increase is effective.

Any request that would change the Death Benefit or any other benefit or rider under the policy will not be processed if the change would cause the policy to be classified as a Modified Endowment Contract. Requested changes that could cause the policy to be classified as a Modified Endowment Contract include, but are not limited to a withdrawal that would cause a reduction in the Face Amount.

Other Distributions of Accumulated Value – If the Net Amount at Risk ever exceeds three times the original Face Amount, we reserve the right to make a distribution of Accumulated Value to make the Net Amount at Risk equal three times the original Face Amount. In such case, the distribution will be treated as a premium refund. Note that while such a distribution will be treated as a premium refund for certain contract purposes, normal tax rules will apply in determining the amount of such a distribution, if any, which is taxable.

Additional Services – While this policy is In Force, we may, either directly or through a third party service provider, provide you with access to independent living-related resources and discounted independent living-related goods and services.

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PACIFIC LIFE

Pacific Life Insurance Company, 45 Enterprise, Aliso Viejo, CA 92656

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- **Death Proceeds Payable On The Death Of The Insured**
- **Net Cash Surrender Value Payable Upon Surrender**
- **Adjustable Face Amount**
- **Non-Participating**

P11PPC

READABILITY CERTIFICATION

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

Policy Form Numbers & Flesch Scores:		
	P11PPC	50.1
	R11ABR	50.0
	R11EBR	50.0
	R11LRD	70.6
	R11AVT	50.1
	A11PPC	50.2
	A11SOH	50.6
	A11TIA	50.1

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

Test type: 10 point

I certify that in my judgment this filing is:

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

I believe this filing:

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

Signed for the Company at Aliso Viejo, California on 08/09/2011

SIGNATURE

THOMAS S. BEADLESTON
NAME

VICE PRESIDENT
TITLE

ACCELERATED BENEFIT RIDER ("ABR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider accelerates the Policy's benefits by reimbursing the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy and this Rider are received to examine and return both of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and this Rider, but both must be returned together. The Policy and Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund the full amount of any premium paid for both the Policy and this Rider within 30 days of such a Policy and Rider return and the Policy and Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy. Defined terms are usually capitalized to show emphasis.

ABR Benefit Duration – The period of coverage under this Rider. The ABR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The ABR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

Activities of Daily Living – means the following self-care functions:

> **Bathing –** Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
> **Continence –** The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
> **Dressing –** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
> **Eating –** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
> **Toileting –** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
> **Transferring –** Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that:

(a) Has the appropriate state licensure or certification as an Assisted Living Facility where required; and
(b) Meets all of the following requirements:

- Provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;

- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- Performance of comprehensive individualized Assessments, including reassessments as needed;
- Development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in the Insured's condition; and
- Coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by the Insured or Representative and determined necessary by the Care Coordinator.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under this Rider. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;

- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients;
- Provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- Have the appropriate state licensure or certification, where required or available.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified or complies with the state's facility licensing requirements and provides a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

In Force – means that this Rider is in effect.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum ABR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum ABR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum ABR Benefit Limit will be reduced when:

- A payment of benefit is made in accordance with the terms of this Rider;
- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum ABR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit, International Benefit and Alternative Care Benefit. The initial Monthly Maximum ABR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will be reduced when:

- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. It also:

- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and
- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- The Insured's functional or cognitive abilities;
- The Insured's social situation; and
- The Insured's care service needs.

Policy – means the life insurance policy to which this Rider is attached.

Policy Date – means the date the Policy and this Rider become effective.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative – means a person or entity legally empowered to represent the Insured.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Spouse – means the person to whom the Insured is legally married or the Insured's partner in a civil union or domestic partnership.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The applicable Elimination Period has been satisfied;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum ABR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

The Owner must elect to accelerate benefits under the Policy by making a claim for benefits under this Rider.

If the Insured is a Chronically Ill Individual due to a Severe Cognitive Impairment, the need for Substantial Supervision must be such that the Insured:

- Does not continue to operate a motor vehicle;
- Requires assistance to take medication;
- Is not left alone for substantial portions of the day; and
- If the Insured is a resident in a Nursing Home Facility, Hospice Care Facility, or Assisted Living Facility, the Insured is not able to leave that facility without competent adult supervision.

Elimination Period – The applicable Elimination Period must be completed before benefits are payable. The Policy Specifications show the number of days for the Elimination Period.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum ABR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum ABR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit;
- Alternative Care Benefit; and
- International Benefit.

CARE COORDINATION

Care Coordination – Care Coordination helps the Insured identify his specific care needs and the long-term care services and programs in his area that can best meet those needs. The Insured may use a Care Coordinator to help him make the most informed decision regarding his care.

About Care Coordination – Care Coordination provides the Insured with the knowledge and training of a Care Coordinator who will review his unique situation and develop Plans of Care to meet his needs. The Care Coordinator will:

- Assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis;
- Work with the Insured to determine the specific services required;
- Develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the needs of the Insured;
- Coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and
- Help the Insured arrange for care, if desired.

Care Coordination is Voluntary – Care Coordination is advisory only. The Insured is not required to use Care Coordination to arrange for care providers or to use the specific care providers identified in the Plan of Care. However, all the Insured's Rider benefits must be provided in accordance with an approved Plan of Care.

Limited Availability Outside United States – Care Coordination other than performing an Assessment or developing a Plan of Care is not available for care received outside the United States.

Transition Planning – If the Insured desires, the Care Coordination Provider will recommend a transition plan that specifies how the Insured's care needs may be met once:

- The Insured has exhausted the benefits under his Rider; or
- The Insured is no longer a Chronically Ill Individual but needs some continued level of assistance.

Care Coordination Provided by Us – Care Coordination provided by us does not require a claim for benefits under this Rider. Any Care Coordination provided by us will not reduce the Maximum ABR Benefit Limit or the Monthly Maximum ABR Benefit Amount.

CARE COORDINATION BENEFIT

Care Coordination Benefit – Benefits are payable for Covered Expenses for Care Coordination that is not performed by us. The Covered Expenses and the amount of the benefit we pay are described below.

Covered Expenses – Covered Expenses for Care Coordination means expenses the Insured incurs, while the Insured is a Chronically Ill Individual, for Care Coordination that is not performed by us.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Care Coordination during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NURSING HOME BENEFIT

Nursing Home Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in a Nursing Home Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for a Nursing Home Facility means expenses the Insured incurs during his Confinement in a Nursing Home Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Nursing Home Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Nursing Home Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Nursing Home Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses also include fees charged for Hospice Care provided by a Hospice Care Facility.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

ASSISTED LIVING FACILITY BENEFIT

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses during the Insured's Confinement in an Assisted Living Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for an Assisted Living Facility means expenses the Insured incurs during his Confinement in an Assisted Living Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Assisted Living Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Assisted Living Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured's bed in the Assisted Living Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured was a Chronically Ill Individual and incurring Covered Expenses during the month.

HOME AND COMMUNITY CARE BENEFIT

Home And Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for Home and Community Care means fees charged for the following services when provided to the Insured by a Home Health Care Agency:

- Home Health Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care and Respite Care.

Covered Expenses also includes fees charged for Adult Day Care provided by an Adult Day Care Center.

Criteria for Receiving Care from an Independent Provider – The Independent Provider must be licensed or certified in the state where the care will be provided, if licensing or certification is required or available for the services provided. A home health aide or certified nursing assistant must present written proof of completion of an established training course or written proof of licensure or certification. The education must include training in safely assisting persons with all Activities of Daily Living. We will accept as proper credentials the home health aide's or certified nursing assistant's inclusion in a government-sponsored nurse aide registry. If the state in which the Insured lives does not require or accept licensure or certification for Independent Providers, then we may approve benefits for an Independent Provider if we can determine that the individual is qualified by training and experience to provide Home Health Care Services and Maintenance or Personal Care Services.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care during the policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the policy month, the benefit for the month will be pro-rated. It will consist of the Insured's Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

INTERNATIONAL BENEFIT

International Benefit – The Insured is eligible to receive cash benefits when Confined in a Nursing Home Facility outside the United States. The conditions under which we will pay this International Benefit and the amount of benefit payable are described below.

Conditions for International Benefits – This cash benefit will be available beginning on the day the Insured first satisfies the Eligibility for the Payment of Benefits requirements and is Confined in a Nursing Home Facility outside the United States. This benefit is in lieu of all other benefits under this Rider.

The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and Confined in a Nursing Home Facility outside the United States. For proof that the Insured is Confined in a Nursing Home Facility outside the United States, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. Proof that the Insured is a Chronically Ill Individual must be provided every 90 days. The cost for providing any of the proof required for this benefit is the responsibility of the Owner.

The Insured must notify us in advance to receive benefits under this provision. The notice must be made in writing and in English. If we are not notified prior to the date of admission to the Nursing Home Facility, then the first date the Insured is eligible for this benefit is the date we receive satisfactory written notice of an eligible Nursing Home Facility stay.

The International Benefit will end at the earliest of the date on which the Insured:

- Has received the Maximum ABR Benefit Limit;
- Is no longer a Chronically Ill Individual;
- Is no longer Confined in a Nursing Home Facility; or
- Returns to the United States.

No other benefit under this Rider is payable during a Policy month for which the Insured receives the International Benefit.

If the Insured is currently in claim in the United States, the Insured cannot leave the United States and be eligible for the International Benefit.

How Much We Will Pay – Benefits are payable for each month that the Insured meets the Conditions for International Benefits. We will pay the Monthly Maximum Benefit ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and Confined in a Nursing Home Facility each day of the Policy month, the benefit for the month will be pro-rated. It will consist of 1/30 of the Insured's Monthly Maximum Benefit ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual during the month.

All benefit payments will be made in U.S. dollars.

ALTERNATIVE CARE BENEFIT

Alternative Care Benefit (For expenses not otherwise covered, but authorized by us) **–** We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in this Rider.

Covered Expenses – Benefits and services can be authorized if we determine that they:

- Are cost-effective;
- Are appropriate to the Insured's needs;
- Are consistent with general standards of care;
- Provide the Insured with an equal or greater quality of care; and
- Are for and constitute Qualified Long-Term Care Services.

Any benefits, treatments, or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician.

We reserve the right to decline to authorize benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once the Insured has exhausted the benefits under this Rider. Agreement to participate in Alternative Care Benefits will not waive any of the rights the Insured or we have under this Rider.

Alternative Care Benefits may be discontinued at any time without affecting the Insured's right to the benefits otherwise available under this Rider.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NON-CONTINUAL ALTERNATIVE CARE BENEFIT

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Non-Continual Alternative Care Benefits. The amount of the benefit we will pay and the conditions under which we will pay this benefit are described below.

Covered Expenses – Covered Expenses for the Non-Continual Alternative Care Benefit means Covered Expenses the Insured incurs for the following, as described below:

- Home Modification; and
- Durable Medical Equipment.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Our determination of whether the Home Modification is a cost-effective alternative will occur within a reasonable period of time. Benefits are not payable for any expenses incurred prior to the date of agreement between the Owner, the Insured, and us. Agreement to participate in Home Modification under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Rider.

Covered Home Modification Expenses – Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to the Insured's Home is a cost-effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance his ability to perform the Activities of Daily Living and allow the Insured to remain in his or her Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Durable Medical Equipment under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. The Durable Medical Equipment must be located in the Insured's Home.

Covered Durable Medical Equipment Expenses – Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in the Insured's Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment. This benefit is subject to the Non-Continual Alternative Care Benefit Lifetime Maximum shown on the Policy Specifications.

CAREGIVER TRAINING BENEFIT

Caregiver Training Benefit – Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in his or her Home.

Covered Expenses – Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice

Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return Home, where the Insured can be cared for by the person receiving the training.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Caregiver Training. This benefit is subject to the Caregiver Training Benefit Lifetime Maximum shown on the Policy Specifications.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is the Monthly Maximum ABR Benefit Amount applicable on the Policy Date, adjusted for withdrawals and for benefits paid under the Terminal Illness Benefit; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times (B divided by C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is the new Monthly Maximum ABR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum ABR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request; or
- The date the Maximum ABR Benefit Limit has been paid.

ABR RETURN OF PREMIUM BENEFIT

ABR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the ABR Return of Premium Benefit is equal to the ABR Premium, as shown on the Policy Specifications. After issue, the ABR Return of Premium Benefit may be reduced (but not below zero) as described in the Policy, after the reduction of the Life Return of Premium Benefit.

EFFECT OF RIDER ON POLICY

Effect of Benefit Payment Under This Rider on Death Proceeds – We reserve the right to withhold any portion of the Death Proceeds that would otherwise be payable for a reasonable period of time under the facts and circumstances to allow verification that we have received all remaining claims for Covered Expenses incurred before the date of death of the Insured.

Effect of Benefit Payment Under This Rider on Policy Withdrawals – Once a claim for benefit payment under this Rider has been received by us, no withdrawals may be made under the Policy.

Effect of Benefit Payment Under This Rider on Policy's Face Amount – Benefit payment under this Rider will reduce the Policy's Face Amount. The reduction in the Policy's Face Amount after payment of the benefit is calculated as A times the result of (B divided by C) where:

A. Is the Policy's Face Amount prior to payment of the benefit;
B. Is the benefit payment; and
C. Is the Maximum ABR Benefit Limit before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Accumulated Value – Benefit payment under this Rider will reduce the Policy's Accumulated Value. The Policy's Accumulated Value after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Policy's Accumulated Value prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy Debt – If there is a loan outstanding under the Policy at the time a benefit under this Rider is payable, a portion of the benefit will be applied towards repayment of the loan. The amount of the benefit that will be allocated as a loan repayment will be calculated as A times the result of (one minus (B divided by C)) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

The Policy Debt after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy's Coverage Charge – Benefit payment under this Rider will reduce the Policy's Coverage Charge. The Coverage Charge after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Coverage Charge prior to payment of the benefit;
B. Is the Policy's Face Amount after the benefit payment; and
C. Is the Policy's Face Amount before the benefit payment.

EFFECT OF POLICY ON RIDER

Effect of Withdrawals on This Rider – Any withdrawal made under the Policy will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

The new Maximum ABR Benefit Limit after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the withdrawal;
B. Is the Policy's Face Amount after the withdrawal; and
C. Is the Policy's Face Amount before the withdrawal.

Effect of Terminal Illness Benefit Payment on this Rider – Any amount paid under the Terminal Illness Benefit will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

The new Maximum ABR Benefit Limit after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the Terminal Illness Benefit Payment;
B. Is the Policy's Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy's Face Amount before the Terminal Illness Benefit Payment.

EXCLUSIONS AND LIMITATIONS

Benefits under this Rider will not be limited or excluded by type of illness, treatment, medical condition or accident, except as provided in this section. In this section, we state the conditions under which payment will be limited, or not made at all, even if the Insured otherwise qualifies for benefits. These conditions apply to all benefits provided by this Rider.

Exclusions – This Rider will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - He or she is a regular employee of an organization which is providing the treatment, service or care; and
  - The organization receives the payment for the treatment, service or care;
- Care or services for which no charge is made in the absence of insurance;
- Care or services provided outside the United States of America, except as provided for under the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);

- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while this Rider is not In Force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion – We will not reduce or deny any claim under this Rider because of a sickness or physical or medical condition disclosed on the Application.

Non-Duplication With Other Plans – We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in this Rider. The Care Coordinator can assist in identifying other insurance benefits to which the Insured is entitled that can be applied to meet actual expenses.

CLAIMS PROVISIONS

In this section, we describe when we must be notified of a claim; what to send us; how we evaluate and pay claims; and other rights and responsibilities under the Rider.

The Insured's Role in the Claims Process – Early awareness by us will facilitate a timely claim review. It is important that the Owner or Insured notify us immediately when the Owner or Insured thinks the Insured is eligible for benefits under this Rider. To file a claim, the Owner or Insured may call us, notify us in writing or submit a completed claim form we provide.

Notify Us as Soon As Possible – We can handle the claim request more efficiently if we are notified within 30 days after the Insured is eligible for benefits or as soon as reasonably possible. We prefer to be notified as soon as the Insured first becomes disabled to the extent that the Insured may soon need care covered by this Rider. Notify us even if the Owner or Insured is unsure, and we can help determine whether the Insured is eligible for benefits.

How Claims Are Evaluated – When notice of claim is received, we will collect the information we need to verify whether the Eligibility for the Payment of Benefits requirements have been met. We may need to contact the Insured's Physician or other care provider and to review the Insured's medical records. Based on our evaluation of this information, we will verify the Insured's eligibility for benefits. We will not pay benefits until we verify eligibility for benefits. If we determine that the Insured is eligible for benefits, we will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordinator.

Cross Border Rules – Benefits will be paid for similar services obtained in a state other than the Policy state of issue if benefits for those services would have been paid in the Policy state of issue, irrespective of any facility licensing, certification or registration requirement (or similar requirements) differences between the states.

Claim Forms – We will provide claim forms for the filing of proofs of loss when we receive the notice of claim. If the Owner, Insured or Insured's Representative does not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending us a letter which describes the occurrence, the character and the extent of the loss for which the claim is made. That letter must be sent to us at our Administrative Office within the time noted below under Proof of Loss.

Proof of Loss – In the case of a claim for continuing loss for which this Rider provides any periodic benefits, written proof of loss must be given to us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be

given to us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than one year after the date the proof is otherwise required.

Written Notification – The Owner will be notified in writing whether or not the Insured is eligible for benefits. We will provide notification within ten days of receiving all the required information. If the Owner wants to receive information related to such denial, that information will be sent to the Owner within 60 days of receipt of his or her written request.

When Benefit Payments Will Be Made – Once the applicable Elimination Period has been completed, benefit payments will be made upon our receipt of the required written claims and evidence of the Insured's continued eligibility. Benefit payments will be made as long as the loss and our liability continue. When a claim is paid, the Owner will receive an Explanation of Benefits from our Administrative Office.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner unless otherwise assigned. Any benefits to which the Owner is entitled that are unpaid at the Insured's death will be payable to the Owner. If benefits are payable to an estate, we may pay a portion of those benefits, up to $5,000, directly to the Owner's spouse or someone related to the Owner by blood or marriage who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examination – At our expense, we have the right to require an examination of the Insured's functional or cognitive status when a claim is made and at reasonable intervals while benefits are being claimed.

How the Owner or Insured Can Appeal a Claim Decision – If the Owner or Insured disagrees with our decision regarding a claim, the Owner may request in writing within 60 days of that decision that we reconsider the claim. The Owner or Insured should submit any additional information that the Owner or Insured feels we need to review our decision. The Owner or Insured should include the names, addresses, and phone numbers of any care providers we should contact to learn more about the loss. The Owner is responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider our decision and send written notification of the results to the Owner. If we deny the appeal request and the Owner wants to receive written information related to such denial, that information will be sent within 60 days of receipt of the written appeal request. This Rider will comply with any requirements regarding external review of claim decisions.

Legal Actions – No action may be brought to recover under this Rider until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given.

Direct Payment of Benefits to Care Provider (Assignment of Benefits) – The Owner may instruct us to pay benefits due under this coverage directly to a Nursing Home Facility, Assisted Living Facility, Hospice Care Facility, Adult Day Care Center or Home Health Care Agency providing the care for which we are reimbursing expenses. The care provider must also agree to the assignment of benefits. The Owner must notify us by Written Request. An assignment will take place only when recorded at our Administrative Office. When received, the assignment will take effect as of the date the Written Request was signed. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of any assignment.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

In this section, we describe such things as the premium for this Rider and the reinstatement provisions.

Non-Cancellable – This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision. The premiums under this Rider are paid by a single premium on or before the Policy Date and cannot be increased.

Paying Premiums, Single Premium – In order for this Rider to be In Force, a single premium covering the entire cost of the Rider must have been paid to us on or before the Policy Date.

Protection Against Unintentional Lapse – In order to protect the Policy and Rider against unintentional lapse, at least one person in addition to the Owner must be designated to receive notice of lapse or termination or the Owner must sign a waiver electing not to designate an additional person to receive notice. The Owner may change this designation at any time. To do so, notify us in writing. We will remind the Owner in writing every two years of this opportunity.

Grace Period – The Grace Period provision in the Policy applies to this Rider.

Notification of Non-Payment – The Notification of Non-Payment provision in the Policy applies to this Rider.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any ABR Return of Premium Benefit.

Reinstatement – If the Policy is reinstated under its Reinstatement provision, this Rider is also eligible to be reinstated provided that such reinstatement occurs within six months from the end of the Grace Period. After the six-month period, this Rider will not be reinstated, even if the Policy is reinstated.

Added Protection Against Lapse – If coverage terminates due to lapse, we will provide a reinstatement of coverage as specified below, if certain conditions are met. To be eligible for this reinstatement, the Insured must provide us proof that the Insured was a Chronically Ill Individual, beginning on or before the date of termination.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner that demonstrates that the Insured was a Chronically Ill Individual. The proof must be provided to us within five months of the termination date. The Owner must pay all past due premiums and outstanding Policy Debt prior to the date of lapse. In that event, the Policy and this Rider will be reinstated as of the date of that termination without interruption of insurance for that period.

Requirements for Reinstatement – If this Rider is eligible to be reinstated, in order for us to evaluate your request for reinstatement, you must satisfy the requirements for reinstatement of the Policy and this Rider. Unless reinstated as described in Added Protection Against Lapse, we reserve the right to charge a fee not to exceed $500 to evaluate insurability in connection with your reinstatement application.

Reinstatement of the Policy and this Rider is effective upon our approval of your reinstatement application. If we issue a temporary insurance agreement in connection with the premium tendered for reinstatement, and we do not act to approve the application, the reinstatement is effective on the 45th day following the date of the temporary insurance agreement unless we have given notice to the Owner of our disapproval of the application prior to the expiration of the 45 day time limit.

If approved, the Policy and this Rider will be reinstated retroactive to the date of termination of coverage. In all other respects, including benefits for Covered Expenses, the Owner will have the same rights under this Rider as prior to the termination. Any amount refunded due to lapse in connection with the ABR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy are cancelled pursuant to the Owner's request;
- The date the Maximum ABR Benefit Limit has been paid; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility before the date of termination in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Elimination Period and Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy and Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

QUALIFIED LONG-TERM CARE SERVICES

Benefit for Qualified Long-Term Care Services – This Rider provides benefits for Qualified Long-Term Care Services received by a Chronically Ill Individual provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. Benefits for Qualified Long-Term Care Services are conditioned on a determination that the Insured is a Chronically Ill Individual.

Certification by A Licensed Health Care Practitioner – Certification that the Insured is a Chronically Ill Individual shall be performed by a Licensed Health Care Practitioner. Such certifications may be performed by a Licensed Health Care Practitioner at our direction as is reasonably necessary with respect to a specific claim, except that when a Licensed Health Care Practitioner has certified that the

Insured is a Chronically Ill Individual and the Owner or Insured has made a claim for benefits under this Rider, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period starting on the date of certification.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable under this Rider to the correct amount using the Insured's correct sex or birth date as of the Policy Date. If, based on the Insured's correct sex or birth date, the Application would not have been accepted and this Rider not issued, we will cancel this Rider and will only be liable for the refund of all premiums paid for this Rider.

Fraud/Recovery – If we determine that benefits have been paid under the Policy or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If, on the Policy Date, this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change.

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EXTENDED BENEFIT RIDER ("EBR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider extends the benefits provided by the Accelerated Benefits Rider ("ABR") for Long-Term Care. The benefits of this Rider become effective after payments for Covered Expenses under the ABR have reached the Maximum ABR Benefit Limit. This Rider reimburses the Owner shown on the Policy Specifications for expenses the Insured incurs for Qualified Long-Term Care Services. This Rider is Non-Cancellable.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to be tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. **You are advised to consult with your personal tax advisor.**

30-Day Right to Examine – The Owner has 30 days from the day the Policy, ABR, and this Rider are received to examine and return all of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy, ABR, and this Rider, but all must be returned together. The Policy, ABR, and this Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund the full amount of any premium paid for the Policy, ABR, and this Rider within 30 days of such a return and the Policy, ABR, and this Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy or the ABR. Terms used in this Rider, the Policy and the ABR will have the same definition unless stated otherwise in this Rider. Defined terms are usually capitalized to show emphasis.

EBR Benefit Duration – The period of coverage under this Rider. The EBR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The EBR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

In Force – means that this Rider is in effect.

Maximum EBR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum EBR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum EBR Benefit Limit will be reduced when a payment of benefit is made in accordance with the terms of this Rider.

Monthly Maximum EBR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit and Alternative Care Benefit. The initial Monthly Maximum EBR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum EBR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is covered under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum EBR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

If the Insured is a Chronically Ill Individual due to a Severe Cognitive Impairment, the need for Substantial Supervision must be such that the Insured:

- Does not continue to operate a motor vehicle;
- Requires assistance to take medication;
- Is not left alone for substantial portions of the day; and
- If the Insured is a resident in a Nursing Home Facility or Assisted Living Facility, the Insured is not able to leave that facility without competent adult supervision.

Conditions – In addition to meeting the Eligibility for the Payment of Benefits criteria shown above, the following conditions must also be met in order for benefits to be paid under this Rider:

- The Owner must elect to claim benefits under this Rider; and

- The Covered Expense incurred for which benefits are claimed under this Rider must occur after the Maximum ABR Benefit Limit has been exhausted.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider's applicable benefit-specific maximums and the Maximum EBR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum EBR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit; and
- Alternative Care Benefit.

LONG-TERM CARE BENEFITS

Long-Term Care Benefits – This Rider extends the benefits provided under the ABR by providing a Maximum EBR Benefit Limit and a Monthly Maximum EBR Benefit Amount, which become effective when the Maximum ABR Benefit Limit under the ABR is exhausted.

Specific Benefits – The specific benefits in the ABR to which this extension applies are the following:

- Care Coordination;
- The Care Coordination Benefit;
- The Nursing Home Benefit;
- The Assisted Living Facility Benefit;
- The Home and Community Care Benefit;
- The Alternative Care Benefit;
- The Non-Continual Alternative Care Benefit; and
- The Caregiver Training Benefit.

Differences from the ABR – When benefits are payable under this Rider, the benefits shown above will be paid as described in the ABR except for the following:

- References in the ABR to the Maximum ABR Benefit Limit will be considered to be references to the Maximum EBR Benefit Limit shown on the Policy Specifications;
- References in the ABR to the Maximum Monthly ABR Benefit Amount will be considered to be references to the Monthly Maximum EBR Benefit Amount;
- This Rider does not provide an International Benefit; and
- The Elimination Period does not apply to this Rider.

If benefits that are subject to the Maximum Monthly ABR Benefit Amount become payable partly under both this Rider and the ABR (because the Maximum ABR Benefit Limit has been exhausted during the month), the maximum amount payable under all such benefits is limited to the greater of:

- The Monthly Maximum ABR Benefit Amount; and
- The Monthly Maximum EBR Benefit Amount.

Benefits payable under the Non-Continual Alternative Care Benefit and the Caregiver Training Benefit of this Rider will:

- be reduced by the respective amounts for which payment is made under the ABR; and
- not be provided if the respective lifetime maximum benefit has been exhausted under the ABR.

The terms, conditions and exclusions of the ABR apply to the payment of benefits under this Rider unless otherwise stated in this Rider.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is the Monthly Maximum EBR Benefit Amount applicable on the Policy Date; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times (B divided by C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is the new Monthly Maximum EBR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum EBR Benefit Amount.

Compound Inflation Benefit Option – If this Option is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured's death;
- The date this Rider and the Policy and ABR are cancelled pursuant to the Owner's request; or
- The date the Owner has received the Maximum EBR Benefit Limit allowed.

EBR RETURN OF PREMIUM BENEFIT

EBR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable if the Policy is surrendered or lapsed. At issue, the EBR Return of Premium Benefit is equal to the EBR Premium, as shown on the Policy Specifications. After issue, the EBR Return of Premium Benefit may be reduced as described in the Policy, after the reduction of the Life Return of Premium Benefit and the ABR Return of Premium Benefit.

NONFORFEITURE BENEFIT

Nonforfeiture Benefit – Upon lapse of this Rider, the Owner is eligible for one of the two options described below. The Owner can change the elected benefit at any time before lapse by sending us a Written Request. The options available are:

1. Return of Premium Benefit as described in this Rider. This option will be effective automatically unless the Owner requests otherwise in writing.
2. Shortened Benefit Period. Under this option, we will continue coverage of eligible claims until the earlier of:
    a. The death of the Insured; or
    b. The date the Nonforfeiture Benefit Limit has been reached.

Nonforfeiture Benefit Limit – is an amount equal to the greater of:

a. The Monthly Maximum EBR Benefit Amount; or
b. The EBR Premium, as shown in the Policy Specifications.

The Nonforfeiture Benefit Limit is reduced by the sum of all benefits previously paid under this Rider. The Nonforfeiture Benefit Limit will never be greater than the remaining amount payable had this Rider stayed In Force.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – This Rider will not pay benefits for any expenses incurred:

- Prior to the date the Maximum ABR Benefit Limit has been exhausted under the ABR; or
- That would have been excluded from payment under the ABR had it remained In Force (as stated in the Exclusions and Limitations provision of that rider).

CLAIMS PROVISIONS

The Claims Provisions in the ABR apply to the payment of benefits under this Rider.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

The Premiums, Lapse and Reinstatement provisions of the ABR apply to this Rider, except as modified below.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any EBR Return of Premium Benefit.

Reinstatement – If the ABR is reinstated under its Reinstatement provision, this Rider will also be reinstated. Any amount refunded due to lapse in connection with the EBR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner's Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy, the ABR and this Rider are linked and must all either remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured's death;
- The date this Rider, the ABR and the Policy are cancelled pursuant to the Owner's request;
- The date the Owner has received the Maximum EBR Benefit Limit allowed under this Rider; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy, the ABR and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured's Confinement in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility before the date the Policy, the ABR or this Rider ended in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility; or
- The date when the Policy's Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy's Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy, the ABR and this Rider.

If the Insured's benefits are continued under this provision, no Death Benefit will be payable.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured's acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

Misstatement – If the Insured's sex or birth date is misstated in the Application, we will adjust the benefits payable under this Rider to the correct amount using the Insured's correct sex or birth date as of the Policy Date. If based on the Insured's correct sex or birth date the Application would not have been accepted and this Rider not issued, we will cancel this Rider and will only be liable for the refund of all premiums paid for this Rider.

Fraud/Recovery – If we determine that benefits have been paid under the Policy, the ABR, or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy, the ABR, or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Conformity With Internal Revenue Code – If on the Policy Date this Rider does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because this Rider is non-cancellable, we will inform the Owner in writing of any required change in the provisions of this Rider; and the Owner will be given the choice of accepting the change, or retaining this Rider without that change.

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PACIFIC LIFE INSURANCE COMPANY
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PACIFIC LIFE

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE

Rider Forms R11ABR and R11EBR

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

CAUTION: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application will be attached to any issued Policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy and Riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: [45 Enterprise, Aliso Viejo, CA 92656].

1. THIS POLICY AND THE RIDERS PROVIDE INDIVIDUAL COVERAGE

The Policy is a flexible premium adjustable life insurance policy with individual long-term care insurance Riders. If the base life insurance Policy is issued, the Accelerated Benefit Rider (ABR) will also be issued. The coverage under the ABR provides two years of long-term care insurance benefits by accelerating payment of the life insurance policy's face amount. The Extended Benefit Rider (EBR) is an optional purchase and provides between one and six years of additional long-term care benefits, depending on the duration elected. You may elect to purchase the Policy and ABR without purchasing the EBR. This outline of coverage describes both the ABR and the EBR (Riders). Capitalized terms used in this outline of coverage are defined in the Definitions section, starting on page 8.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Riders contain governing contractual provisions. This means that the Policy and Riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

These Riders are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS COVERAGE IS NONCANCELLABLE – This means you have the right, subject to the terms of your Policy and Riders, to continue your coverage as long as the single premium is paid. We cannot change any of the terms of your coverage on our own and cannot require that you pay additional premium after the Riders are issued, including for any Inflation Benefit Option.

Waiver of Premium – A waiver of premium provision waives premium payments that become due when an insured is receiving benefits under the coverage. There is no waiver of premium for these Riders because there is a single premium required and it must be paid prior to the coverage being issued. After issue there are no further premiums required that could be waived.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We do not have the right to change the premium rates for your coverage. This coverage requires a single premium and it must be paid prior to the Policy and Riders being issued. After issue, you will not be required to make any additional premium payments.

6. TERMS UNDER WHICH THE POLICY AND RIDERS MAY BE RETURNED AND PREMIUM REFUNDED

The Owner has 30 days from the day the Policy and Riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and the Riders. The Policy and Riders can be returned to us at our Administrative Office or to the Producer/Representative through whom it was bought. We will refund the full amount of any premium paid within 30 days of such a Policy and Rider return and the Policy and Riders will be void from the start.

Return of Premium Benefit – The Riders each include a Return of Premium Benefit that is payable if the coverage is surrendered or lapsed. At issue, the Return of Premium Benefit is equal to the premium paid for the ABR or EBR, as shown on the Policy specifications. After issue, the Return of Premium Benefit may be reduced by withdrawals, a Terminal Illness Benefit Payment (available under the terms of the Policy) or benefit payments under the Riders, as described in the Riders.

Limited Refund on Death – Some of the premium paid for the Riders may be refunded on the death of the Insured. The amount of refunded premium, if any, will be based on the premium paid for the Riders, adjusted for any death benefit payable under the Policy, benefit payments made under the Riders, Terminal Illness Benefit Payment or withdrawals, as described in the Riders.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor our producers/representatives represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home facility, in the community, or in the home.

With the exception of the International Benefit, which applies only to the ABR, this coverage provides reimbursement benefits. Reimbursement benefits reimburse the Owner for covered long-term care expenses incurred. The International Benefit under the ABR pays indemnity benefits. Indemnity benefits pay a fixed dollar amount regardless of the amount of expenses incurred. All benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE COVERAGE

Benefits are available under the ABR up to the Monthly Maximum Benefit Amount until the Maximum ABR Benefit Limit is reached. The EBR extends most of the benefits provided by the

ABR, subject to the Maximum Benefit Amount, until the Maximum EBR Benefit Limit is reached. The Non-Continual Alternative Care Benefit and the Caregiver Training Benefit are subject to lifetime maximums specific to those benefits. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits for the following Covered Expenses:

Care Coordination and Care Coordination Benefit – Care Coordination is intended to help identify an Insured's specific care needs and long-term care services and programs available to meet those needs. Care Coordination will provide the Insured with a Care Coordinator who will review the Insured's specific situation and develop Plans of Care to meet the Insured's needs. The Care Coordinator will: assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis; work with the Insured to determine the specific services the Insured requires; develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs; coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and help the Insured arrange for care.

Care Coordination provided by us does not require a claim for benefits and does not count against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Care Coordination not performed by us requires a claim for Care Coordination Benefits, which counts against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Benefits are payable for Covered Expenses the Insured incurs for Care Coordination not performed by us during the Policy month up to the Monthly Maximum Benefit Amount.

Nursing Home Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in a Nursing Home Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses also include Hospice Care provided by a Hospice Care Facility. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Nursing Home Benefit will be pro-rated.

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in an Assisted Living Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Assisted Living Facility Benefit will be pro-rated.

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care, which include the following services when provided by a Home Health Care Agency or by an Independent Provider: Home Health Care Services; Maintenance or Personal Care Services; Hospice Care; and Respite Care. Covered Expenses also include Adult Day Care provided by an Adult Day Care Center. Benefits are payable for

the Covered Expenses the Insured incurs for Home and Community Care up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Home and Community Care Benefit will be pro-rated.

International Benefit – The International Benefit is included as part of the ABR only and is not available under the EBR. The Insured is eligible to receive the full Monthly Maximum ABR Benefit Amount when Confined in a Nursing Home Facility outside the United States. No other benefit is payable under the ABR during any Policy month for which the Insured receives the International Benefit. This cash benefit will be available beginning on the date the Insured first satisfies the Eligibility for Payment of Benefits requirements and is Confined to a Nursing Home Facility outside the United States. The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and is Confined in a Nursing Home Facility outside the United States in order to receive this benefit. For proof of this, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. The Insured must provide written proof every 90 days, in English, that the Insured is a Chronically Ill Individual. The cost for providing any proof required for this benefit is the responsibility of the Owner. We must be notified in advance to receive the International Benefit and such notice must be made in writing and in English. Each month the Insured is eligible for the International Benefit, benefits are payable in the amount of the Monthly Maximum ABR Benefit Amount. If the Insured is not a Chronically Ill Individual each day of the Policy month, the International Benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

Alternative Care Benefit – We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the Riders. Benefits and services can be authorized if we determine that they: are cost-effective; are appropriate to the Insured's needs; are consistent with general standards of care; provide the Insured with an equal or greater quality of care; and are for and constitute Qualified Long-Term Care Services. Any benefits, treatments or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician. We reserve the right to decline to authorize benefits and services. Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits.

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment up to the Non-Continual Alternative Care Benefit Lifetime Maximum.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance the Insured's ability to perform the Activities of Daily Living and allow the Insured to remain in the Insured's Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase

such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

Caregiver Training Benefit – Caregiver Training Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in the Insured's Home. Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return to Home where the Insured can be cared for by the person receiving the training. Benefits are payable for the Covered Expenses the Insured incurs for Caregiver Training up to the Caregiver Training Benefit Lifetime Maximum.

Nonforfeiture Benefit of the EBR – Upon lapse of the EBR, the Owner is eligible for a Nonforfeiture Benefit of either the Return of Premium Benefit, as described above under Section 6, or a limited amount of paid-up long-term care benefits, as described in the EBR.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for benefits under the coverage, we must verify that the Insured is a Chronically Ill Individual, as certified by a Licensed Health Care Practitioner within the past 12 months. In addition:

- The cost incurred is a Covered Expense under the coverage and the service for such Covered Expense is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under the Riders must be in force on the dates the care is received;
- The Insured must not have exhausted the applicable limits on the specific benefits claimed, or the Maximum Benefit Limit;
- The Insured must meet the additional requirements for the specific benefits claimed; and
- The Insured must satisfy the applicable Elimination Period.

Long-Term Care Benefits	Elimination Period
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[30] Days
Care Coordination Benefit	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[30] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[30] Days

10. EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions – We will not reduce or deny any claim under the Riders because of a sickness or physical or medical condition disclosed on the application.

Non-eligible Facilities and Providers – Any facility or provider for a given benefit that does not fall within the "Definitions" section, starting on page 8, would be a non-eligible facility or provider for that benefit.

Non-eligible Levels of Care – Coverage does not include any services that do not constitute Qualified Long-Term Care Services. Care from family members is covered only where specifically indicated below in Exclusions/Exceptions and Limitations.

Exclusions/Exceptions and Limitations – We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while the Riders are not in force, except as provided in the provision.

Non-Duplication – We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in the Rider.

Duration – The ABR provides two years of long-term care benefits. The EBR provides between one and six years of additional long-term term care benefits, depending on the duration elected. These durations may increase or decrease depending on how the Policy and Rider benefits are used.

THIS COVERAGE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, consider whether and how the benefits of this coverage may be adjusted. One of the available Inflation Benefit Options may be elected at the time of purchase to increase the coverage. While the Insured will be underwritten in order to purchase the coverage, once the Inflation Benefit Option is in effect, no further underwriting is required. There is a premium charge for including any Inflation Benefit Option in the coverage. The premium charge varies depending on which Inflation Benefit Option is elected.

Unless rejected, one of the following will apply to the Riders:

- 5% Compound Inflation Benefit Option
- 5% Simple Inflation Benefit Option
- 3% Simple Inflation Benefit Option

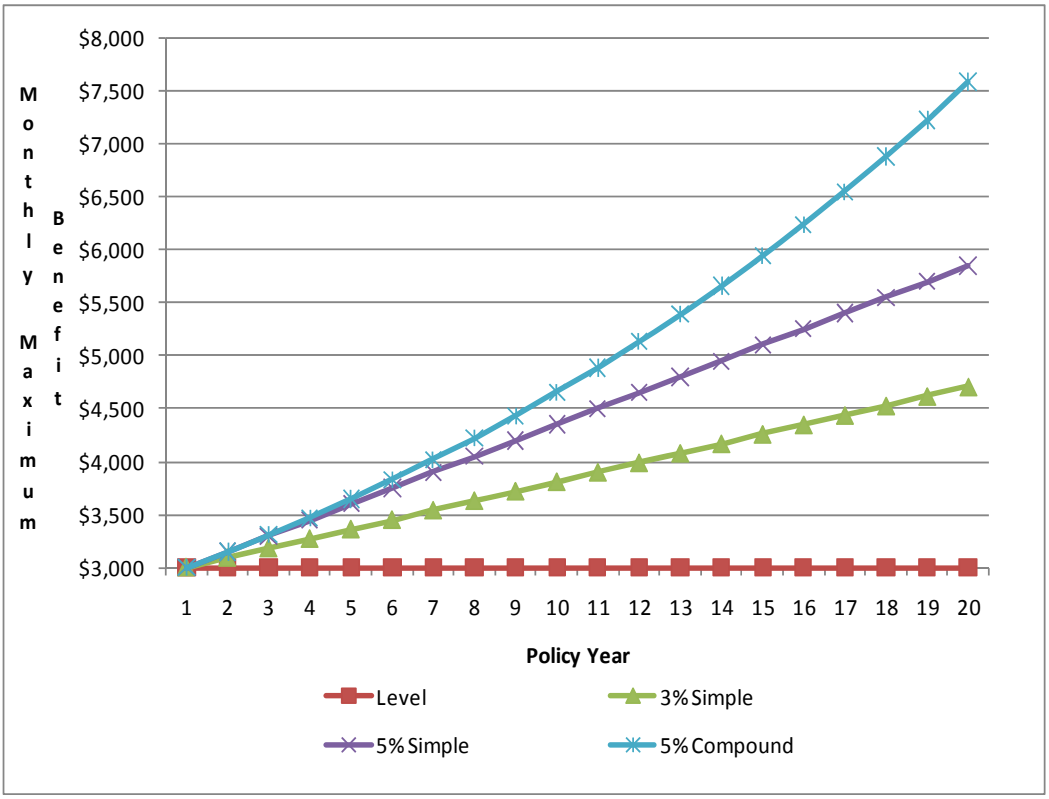
Simple Inflation Benefit Option (3% or 5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to the

selected percentage of the initial Monthly Maximum Benefit Amount. The Maximum Benefit Limits will be increased by the same proportion as the Monthly Maximum Benefit Amount.

Compound Inflation Benefit Option (5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to 5% of the Monthly Maximum Benefit Amount in effect immediately prior to the increase. The Maximum Benefit Limits will also be increased on each Policy anniversary by an amount equal to 5% of the Maximum Benefit Limits in effect immediately prior to the increase.

INFLATION PROTECTION – GRAPHIC COMPARISONS

The following chart compares and contrasts benefit levels for coverage with no inflation protection and coverage with the 3% simple, 5% simple and 5% compound Inflation Benefit Options offered with the coverage. The chart assumes an initial Monthly Maximum Benefit Amount of $3,000.



The following chart shows a relative cost comparison of total premiums with and without an Inflation Benefit Option. At each issue age and gender combination, the chart shows the total premium with the Inflation Benefit Option divided by the total premium without the Inflation Benefit Option. For example, total premiums for a 35 year old female for coverage with the 5% simple Inflation Benefit Option will cost 163% of the total premiums for coverage with no Inflation Benefit Option. The chart assumes a 2 year ABR and 2 year EBR were elected.

Issue Age	Gender	Inflation Option for 4 Year LTC Benefit			
		None	3% Simple	5% Simple	5% Compound
35	Male	100%	117%	130%	215%
	Female	100%	131%	163%	376%
45	Male	100%	121%	140%	192%
	Female	100%	132%	163%	315%
55	Male	100%	124%	150%	173%
	Female	100%	131%	163%	257%
65	Male	100%	124%	148%	162%
	Female	100%	131%	157%	245%
75	Male	100%	121%	138%	160%
	Female	100%	145%	170%	240%

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once an Insured's application is approved, coverage is provided for an Insured who is a Chronically Ill Individual as a result of Alzheimer's disease or any related degenerative and dementing illnesses.

13. PREMIUM

The single premium for the coverage will be determined based on the amount of coverage, the Inflation Benefit Option elected, if any, and the Insured's issue age and gender as described in the application and illustrated in the chart in section 11.

14. ADDITIONAL FEATURES

Underwriting – We will underwrite the Insured's application by reviewing one or more of the following: the information submitted on the application; an attending Physician's report; copies of the Insured's medical records; a medical evaluation; a telephone interview; and an in-person interview.

Added Protection Against Lapse – If the Insured's coverage terminates due to lapse, we will provide a retroactive continuation of coverage if within five (5) months of the termination date the Insured provides us with proof the Insured was a Chronically Ill Individual, beginning on or before the termination date. All past due premiums, outstanding Policy Debt prior to the date of lapse and any amount refunded due to lapse in connection with the Rider Return of Premium Benefit must be paid. In that event, the Policy and Riders will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE COVERAGE.

DEFINITIONS

In this section, we define certain terms used throughout this Outline of coverage. Defined terms are usually capitalized to show emphasis.

ABR – means the Accelerated Benefit Rider.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that:

(a) Has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) Meets all of the following requirements:

- Provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;

- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under the ABR or EBR. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

EBR – means the Extended Benefit Rider.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- Be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients;

- Provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- Have the appropriate state licensure or certification, where required or available.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified or complies with the state's facility licensing requirements and provides a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit Limit – is the total amount of lifetime benefits payable under the ABR or EBR, as applicable, as described in the ABR or EBR.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum Benefit Amount – is the total amount of monthly benefits payable under the ABR or EBR, as applicable.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. It also:

- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and

- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services.

Policy – means the flexible premium adjustable life insurance policy Form P11PPC to which the Riders are attached.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Riders – means the ABR and the EBR.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

Terminal Illness Benefit Payment – means the actual dollar amount of benefit received under the Terminal Illness Benefit of the Policy.

AVIATION EXCLUSION RIDER

Risks Not Covered – This policy does not cover death, disability, or chronic illness or any benefit that would be payable to a Chronically Ill Individual resulting from injuries sustained as a result of riding in, descent with or descent from an aircraft unless:

- The deceased was a fare-paying passenger; and
- The aircraft was being operated by a duly licensed passenger carrier on a regular schedule over its established route.

The amount payable under this policy in the event of death as a result of a risk not covered will be the greater of:

- Total premiums received under this policy (without interest) less any withdrawal amounts, the Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy, and any benefit payments made under the policy riders; or
- An amount equal to the Cash Surrender Value of this policy.

Any existing Policy Debt on this policy will be deducted from the amount payable. However, the total amount payable will not exceed the payment that would have been made in the absence of this rider.

General Conditions – This rider is part of the policy to which it is attached. This rider becomes effective on the Policy Date unless otherwise specified.

Signed for Pacific Life Insurance Company,

[James T. Morris] [Jane M. Guon]

Chairman, President and Chief Executive Officer Secretary

[www.PacificLife.com] [(800) 347-7787]

PACIFIC LIFE INSURANCE COMPANY
[45 Enterprise, Aliso Viejo, CA 92656
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PACIFIC LIFE

LONG-TERM CARE INSURANCE – OUTLINE OF COVERAGE

Rider Forms R11ABR and R11EBR

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all coverage limitations.

CAUTION: The issuance of this long-term care insurance is based upon your responses to the questions on your application. A copy of your application will be attached to any issued Policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy and Riders. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: [45 Enterprise, Aliso Viejo, CA 92656].

1. THIS POLICY AND THE RIDERS PROVIDE INDIVIDUAL COVERAGE

The Policy is a flexible premium adjustable life insurance policy with individual long-term care insurance Riders. If the base life insurance Policy is issued, the Accelerated Benefit Rider (ABR) will also be issued. The coverage under the ABR provides two years of long-term care insurance benefits by accelerating payment of the life insurance policy's face amount. The Extended Benefit Rider (EBR) is an optional purchase and provides between one and six years of additional long-term care benefits, depending on the duration elected. You may elect to purchase the Policy and ABR without purchasing the EBR. This outline of coverage describes both the ABR and the EBR (Riders). Capitalized terms used in this outline of coverage are defined in the Definitions section, starting on page 8.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Riders contain governing contractual provisions. This means that the Policy and Riders set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

These Riders are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS COVERAGE IS NONCANCELLABLE – This means you have the right, subject to the terms of your Policy and Riders, to continue your coverage as long as the single premium is paid. We cannot change any of the terms of your coverage on our own and cannot require that you pay additional premium after the Riders are issued, including for any Inflation Benefit Option.

Waiver of Premium – A waiver of premium provision waives premium payments that become due when an insured is receiving benefits under the coverage. There is no waiver of premium for these Riders because there is a single premium required and it must be paid prior to the coverage being issued. After issue there are no further premiums required that could be waived.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We do not have the right to change the premium rates for your coverage. This coverage requires a single premium and it must be paid prior to the Policy and Riders being issued. After issue, you will not be required to make any additional premium payments.

6. TERMS UNDER WHICH THE POLICY AND RIDERS MAY BE RETURNED AND PREMIUM REFUNDED

The Owner has 30 days from the day the Policy and Riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and the Riders. The Policy and Riders can be returned to us at our Administrative Office or to the Producer/Representative through whom it was bought. We will refund the full amount of any premium paid within 30 days of such a Policy and Rider return and the Policy and Riders will be void from the start.

Return of Premium Benefit – The Riders each include a Return of Premium Benefit that is payable if the coverage is surrendered or lapsed. At issue, the Return of Premium Benefit is equal to the premium paid for the ABR or EBR, as shown on the Policy specifications. After issue, the Return of Premium Benefit may be reduced by withdrawals, a Terminal Illness Benefit Payment (available under the terms of the Policy) or benefit payments under the Riders, as described in the Riders.

Limited Refund on Death – Some of the premium paid for the Riders may be refunded on the death of the Insured. The amount of refunded premium, if any, will be based on the premium paid for the Riders, adjusted for any death benefit payable under the Policy, benefit payments made under the Riders, Terminal Illness Benefit Payment or withdrawals, as described in the Riders.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor our producers/representatives represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home facility, in the community, or in the home.

With the exception of the International Benefit, which applies only to the ABR, this coverage provides reimbursement benefits. Reimbursement benefits reimburse the Owner for covered long-term care expenses incurred. The International Benefit under the ABR pays indemnity benefits. Indemnity benefits pay a fixed dollar amount regardless of the amount of expenses incurred. All benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE COVERAGE

Benefits are available under the ABR up to the Monthly Maximum Benefit Amount until the Maximum ABR Benefit Limit is reached. The EBR extends most of the benefits provided by the

ABR, subject to the Maximum Benefit Amount, until the Maximum EBR Benefit Limit is reached. The Non-Continual Alternative Care Benefit and the Caregiver Training Benefit are subject to lifetime maximums specific to those benefits. You must meet the Eligibility for the Payment of Benefits requirements in order to receive benefits for the following Covered Expenses:

Care Coordination and Care Coordination Benefit – Care Coordination is intended to help identify an Insured's specific care needs and long-term care services and programs available to meet those needs. Care Coordination will provide the Insured with a Care Coordinator who will review the Insured's specific situation and develop Plans of Care to meet the Insured's needs. The Care Coordinator will: assess the Insured's functional, cognitive and personal needs for care and services on an ongoing basis; work with the Insured to determine the specific services the Insured requires; develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the Insured's needs; coordinate and monitor the Insured's care needs on an ongoing basis to help the Insured receive appropriate care; and help the Insured arrange for care.

Care Coordination provided by us does not require a claim for benefits and does not count against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Care Coordination not performed by us requires a claim for Care Coordination Benefits, which counts against the Monthly Maximum Benefit Amount and Maximum Benefit Limits. Benefits are payable for Covered Expenses the Insured incurs for Care Coordination not performed by us during the Policy month up to the Monthly Maximum Benefit Amount.

Nursing Home Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in a Nursing Home Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses also include Hospice Care provided by a Hospice Care Facility. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Nursing Home Benefit will be pro-rated.

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses the Insured incurs during Confinement in an Assisted Living Facility, which include: room and board; ancillary services such as therapy services; patient supplies; Hospice Care and Respite Care; and bed reservation to keep the Insured's bed in the facility while the Insured is absent for any reason except discharge. Covered Expenses do not include expenses the Insured incurs for drugs or any charges for comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. There is a maximum benefit for bed reservation of 30 days per Policy year. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Assisted Living Facility Benefit will be pro-rated.

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care, which include the following services when provided by a Home Health Care Agency or by an Independent Provider: Home Health Care Services; Maintenance or Personal Care Services; Hospice Care; and Respite Care. Covered Expenses also include Adult Day Care provided by an Adult Day Care Center. Benefits are payable for

the Covered Expenses the Insured incurs for Home and Community Care up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits. If the Insured is not a Chronically Ill Individual each day of the Policy month, the Home and Community Care Benefit will be pro-rated.

International Benefit – The International Benefit is included as part of the ABR only and is not available under the EBR. The Insured is eligible to receive the full Monthly Maximum ABR Benefit Amount when Confined in a Nursing Home Facility outside the United States. No other benefit is payable under the ABR during any Policy month for which the Insured receives the International Benefit. This cash benefit will be available beginning on the date the Insured first satisfies the Eligibility for Payment of Benefits requirements and is Confined to a Nursing Home Facility outside the United States. The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and is Confined in a Nursing Home Facility outside the United States in order to receive this benefit. For proof of this, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. The Insured must provide written proof every 90 days, in English, that the Insured is a Chronically Ill Individual. The cost for providing any proof required for this benefit is the responsibility of the Owner. We must be notified in advance to receive the International Benefit and such notice must be made in writing and in English. Each month the Insured is eligible for the International Benefit, benefits are payable in the amount of the Monthly Maximum ABR Benefit Amount. If the Insured is not a Chronically Ill Individual each day of the Policy month, the International Benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

Alternative Care Benefit – We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the Riders. Benefits and services can be authorized if we determine that they: are cost-effective; are appropriate to the Insured's needs; are consistent with general standards of care; provide the Insured with an equal or greater quality of care; and are for and constitute Qualified Long-Term Care Services. Any benefits, treatments or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured's Physician. We reserve the right to decline to authorize benefits and services. Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit up to the Monthly Maximum Benefit Amount and the Maximum Benefit Limits.

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment up to the Non-Continual Alternative Care Benefit Lifetime Maximum.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Home Modification means the cost of Home Modification if the Insured's Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured's Home that will enhance the Insured's ability to perform the Activities of Daily Living and allow the Insured to remain in the Insured's Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured's Plan of Care and is mutually agreeable to the Owner, the Insured and us as a cost-effective alternative to benefits otherwise provided by the Riders. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase

such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

Caregiver Training Benefit – Caregiver Training Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in the Insured's Home. Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return to Home where the Insured can be cared for by the person receiving the training. Benefits are payable for the Covered Expenses the Insured incurs for Caregiver Training up to the Caregiver Training Benefit Lifetime Maximum.

Nonforfeiture Benefit of the EBR – Upon lapse of the EBR, the Owner is eligible for a Nonforfeiture Benefit of either the Return of Premium Benefit, as described above under Section 6, or a limited amount of paid-up long-term care benefits, as described in the EBR.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for benefits under the coverage, we must verify that the Insured is a Chronically Ill Individual, as certified by a Licensed Health Care Practitioner within the past 12 months. In addition:

- The cost incurred is a Covered Expense under the coverage and the service for such Covered Expense is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under the Riders must be in force on the dates the care is received;
- The Insured must not have exhausted the applicable limits on the specific benefits claimed, or the Maximum Benefit Limit;
- The Insured must meet the additional requirements for the specific benefits claimed; and
- The Insured must satisfy the applicable Elimination Period.

Long-Term Care Benefits	Elimination Period
Alternative Care Benefit:	[0] Days
Assisted Living Facility Benefit:	[30] Days
Care Coordination Benefit	[0] Days
Caregiver Training Benefit:	[0] Days
Home and Community Care Benefit:	[0] Days
International Benefit:	[30] Days
Non-Continual Alternative Care Benefit:	[0] Days
Nursing Home Benefit:	[30] Days

10. EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions – We will not reduce or deny any claim under the Riders because of a sickness or physical or medical condition disclosed on the application.

Non-eligible Facilities and Providers – Any facility or provider for a given benefit that does not fall within the "Definitions" section, starting on page 8, would be a non-eligible facility or provider for that benefit.

Non-eligible Levels of Care – Coverage does not include any services that do not constitute Qualified Long-Term Care Services. Care from family members is covered only where specifically indicated below in Exclusions/Exceptions and Limitations.

Exclusions/Exceptions and Limitations – We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured's Immediate Family unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while the Riders are not in force, except as provided in the provision.

Non-Duplication – We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured's Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in the Rider.

Duration – The ABR provides two years of long-term care benefits. The EBR provides between one and six years of additional long-term term care benefits, depending on the duration elected. These durations may increase or decrease depending on how the Policy and Rider benefits are used.

THIS COVERAGE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, consider whether and how the benefits of this coverage may be adjusted. One of the available Inflation Benefit Options may be elected at the time of purchase to increase the coverage. While the Insured will be underwritten in order to purchase the coverage, once the Inflation Benefit Option is in effect, no further underwriting is required. There is a premium charge for including any Inflation Benefit Option in the coverage. The premium charge varies depending on which Inflation Benefit Option is elected.

Unless rejected, one of the following will apply to the Riders:

- 5% Compound Inflation Benefit Option
- 5% Simple Inflation Benefit Option
- 3% Simple Inflation Benefit Option

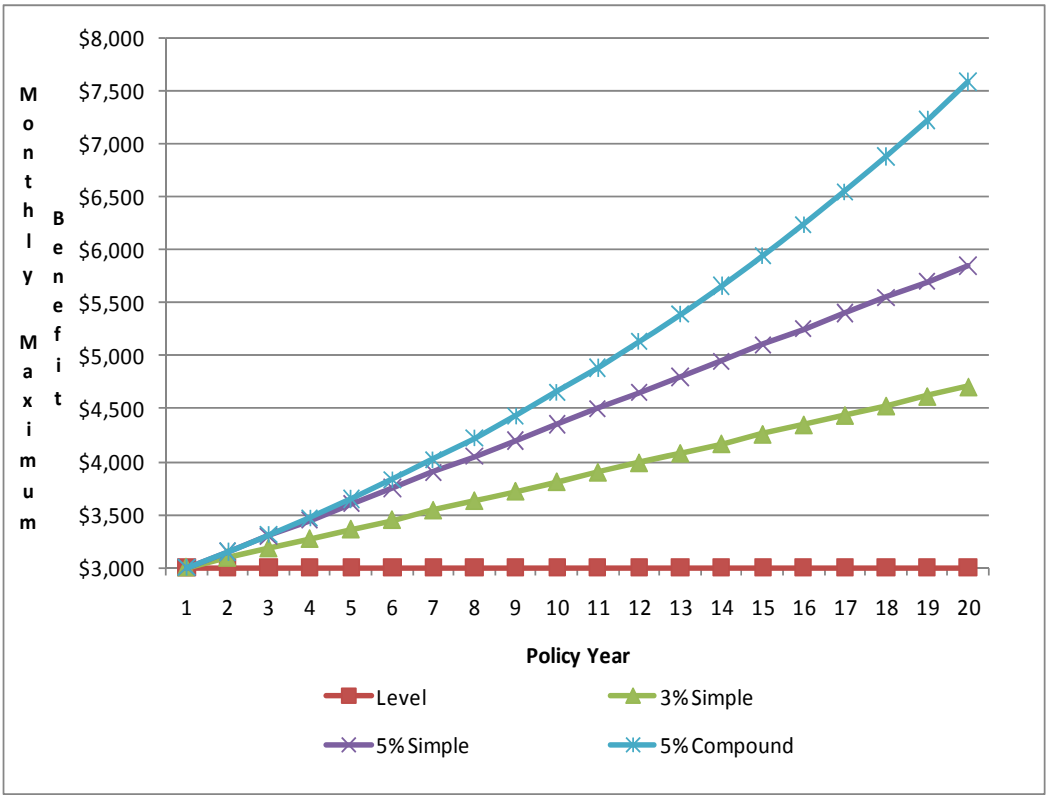
Simple Inflation Benefit Option (3% or 5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to the

selected percentage of the initial Monthly Maximum Benefit Amount. The Maximum Benefit Limits will be increased by the same proportion as the Monthly Maximum Benefit Amount.

Compound Inflation Benefit Option (5%) – If this Option is in effect, the Monthly Maximum Benefit Amount will be increased on each Policy anniversary by an amount equal to 5% of the Monthly Maximum Benefit Amount in effect immediately prior to the increase. The Maximum Benefit Limits will also be increased on each Policy anniversary by an amount equal to 5% of the Maximum Benefit Limits in effect immediately prior to the increase.

INFLATION PROTECTION – GRAPHIC COMPARISONS

The following chart compares and contrasts benefit levels for coverage with no inflation protection and coverage with the 3% simple, 5% simple and 5% compound Inflation Benefit Options offered with the coverage. The chart assumes an initial Monthly Maximum Benefit Amount of $3,000.



The following chart shows a relative cost comparison of total premiums with and without an Inflation Benefit Option. At each issue age and gender combination, the chart shows the total premium with the Inflation Benefit Option divided by the total premium without the Inflation Benefit Option. For example, total premiums for a 35 year old female for coverage with the 5% simple Inflation Benefit Option will cost 163% of the total premiums for coverage with no Inflation Benefit Option. The chart assumes a 2 year ABR and 2 year EBR were elected.

Issue Age	Gender	Inflation Option for 4 Year LTC Benefit			
		None	3% Simple	5% Simple	5% Compound
35	Male	100%	117%	130%	215%
	Female	100%	131%	163%	376%
45	Male	100%	121%	140%	192%
	Female	100%	132%	163%	315%
55	Male	100%	124%	150%	173%
	Female	100%	131%	163%	257%
65	Male	100%	124%	148%	162%
	Female	100%	131%	157%	245%
75	Male	100%	121%	138%	160%
	Female	100%	145%	170%	240%

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once an Insured's application is approved, coverage is provided for an Insured who is a Chronically Ill Individual as a result of Alzheimer's disease or any related degenerative and dementing illnesses.

13. PREMIUM

The single premium for the coverage will be determined based on the amount of coverage, the Inflation Benefit Option elected, if any, and the Insured's issue age and gender as described in the application and illustrated in the chart in section 11.

14. ADDITIONAL FEATURES

Underwriting – We will underwrite the Insured's application by reviewing one or more of the following: the information submitted on the application; an attending Physician's report; copies of the Insured's medical records; a medical evaluation; a telephone interview; and an in-person interview.

Added Protection Against Lapse – If the Insured's coverage terminates due to lapse, we will provide a retroactive continuation of coverage if within five (5) months of the termination date the Insured provides us with proof the Insured was a Chronically Ill Individual, beginning on or before the termination date. All past due premiums, outstanding Policy Debt prior to the date of lapse and any amount refunded due to lapse in connection with the Rider Return of Premium Benefit must be paid. In that event, the Policy and Riders will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE COVERAGE.

DEFINITIONS

In this section, we define certain terms used throughout this Outline of coverage. Defined terms are usually capitalized to show emphasis.

ABR – means the Accelerated Benefit Rider.

Activities of Daily Living – means the following self-care functions:

Bathing – Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
Continence – The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring – Moving into or out of a bed, chair or wheelchair.

Adult Day Care – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center – means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Care – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

Assisted Living Facility – means a facility that is engaged primarily in providing ongoing Assisted Living Care and related services that:

(a) Has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) Meets all of the following requirements:

- Provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;

- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordination – means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services.

Care Coordination Provider – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Care Coordinator – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Confinement or Confined – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under the ABR or EBR. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured's abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured's convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured's body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

EBR – means the Extended Benefit Rider.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured's lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured's inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured's domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- Be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients;

- Provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- Have the appropriate state licensure or certification, where required or available.

Home Health Care Services – means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living and Respite Care.

Home Modification – means the labor, equipment, and supplies used to make changes in the Insured's Home. These changes must be designed to:

- Enhance the Insured's ability to perform Activities of Daily Living; and
- Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Homemaker Services – means assistance with activities necessary to or consistent with the Insured's ability to live safely and independently in his or her Home.

Hospice Care – means services designed to provide palliative care and alleviate the Insured's physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

Hospice Care Facility – means a facility that is appropriately licensed or certified or complies with the state's facility licensing requirements and provides a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family – means the Insured's Spouse and the parents, brothers, sisters and children of either the Insured or the Insured's Spouse by blood, adoption or marriage.

Independent Provider – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

Informal Caregiver – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured's Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

Licensed Health Care Practitioner – means a physician, as defined in sub-section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

Maintenance or Personal Care Services – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit Limit – is the total amount of lifetime benefits payable under the ABR or EBR, as applicable, as described in the ABR or EBR.

Medicare – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Mental or Nervous Disorder – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured's illness will be used.

Monthly Maximum Benefit Amount – is the total amount of monthly benefits payable under the ABR or EBR, as applicable.

Nurse – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

Nursing Home Care – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

Nursing Home Facility – means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing Nursing Home Care to inpatients under a planned program supervised by a Physician. It also:

- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer's Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
- An Assisted Living Facility;
- A Hospice Care Facility;
- An adult residential care home;
- A domiciliary care facility;
- The Insured's primary place of residence in an area used principally for independent residential living; or
- A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

- Meets all of the above criteria;
- Is authorized to provide nursing care to inpatients; and

- Is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) **–** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured's long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services.

Policy – means the flexible premium adjustable life insurance policy Form P11PPC to which the Riders are attached.

Qualified Long-Term Care Services – means services that meet the requirements of § 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Riders – means the ABR and the EBR.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Standby Assistance – means the presence of another person, within arm's reach of the Insured, which is necessary to prevent, by physical intervention, the Insured's injury while the Insured is performing an Activity of Daily Living.

Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

Substantial Supervision – means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to the Insured's health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

Terminal Illness Benefit Payment – means the actual dollar amount of benefit received under the Terminal Illness Benefit of the Policy.

PACIFIC LIFE INSURANCE COMPANY
[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

APPLICATION FOR [PACIFIC PREMIERCARE]

For Individual Life Insurance with Long-Term (LTC) Benefits.

PROPOSED INSURED

1A. Name: First | MI | Last

B. Gender ☐ Male ☐ Female

C. Residence Address: Street | City | State | Zip Code

D. Date of Birth | E. Place of Birth (State/Country) | F. Soc. Sec. # | G. Telephone # (include area code)

2A. Employer's Name | B. Occupation

3A. Proposed Insured is a: ☐ U.S. Citizen ☐ U.S. Permanent Resident ☐ Foreign National

B. If Foreign National, provide Country | C. Visa Type | 4A. Gross Annual Income $ | B. Net Worth $

5. Is the Proposed Insured married or in a legally recognized civil union or domestic partnership? ☐ Yes ☐ No

POLICY INFORMATION

1. Face Amount $ | 2. Single Premium $ | 3. Amount submitted with Temporary Insurance Agreement (TIA) $

4. Long-Term Care (LTC) Benefit Duration: (Includes 2 year Accelerated Benefit Rider plus 0-6 years of Extended Benefit Rider.)
☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years ☐ 7 Years ☐ 8 Years

5. Inflation Benefit Option (select one)
☐ 3% Simple ☐ 5% Simple ☐ 5% Compound ☐ Reject All Inflation Benefit Options

PRIMARY POLICYOWNER (Complete if other than Proposed Insured.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all trustees to sign? ☐ Yes ☐ No (If No, indicate in Remarks who is required to sign.)

ADDITIONAL POLICYOWNER (If more than one individual is named as policyowner, they will own policy as joint tenants with rights of survivorship unless otherwise stated.)

1. Policyowner is ☐ Individual ☐ Trust

2A. Name | B. Relationship to Proposed Insured

C. Address: Street | City | State | Zip Code

D. Soc. Sec. # / Tax ID # | E. Date of Trust | F. Total Number of Trustees

G. Trustee's Name | H. Additional Trustee's Name

I. Does the trust agreement require all Trustees to sign? ☐ Yes ☐ No (If No, indicate who is required to sign in Remarks.)

Payor Of Premium

1. Payor of premium is (Check one): ☐ Proposed Insured ☐ Primary Policyowner ☐ Additional Primary Policyowner ☐ Other

2A. If "Other" indicate Name of Payor

B. Address: Street City State Zip Code

Protection Against Unintended Lapse

I, the Policyowner, understand that I have the right to designate at least one person other than myself to receive notices of lapse or termination of this policy, which contains long-term care benefits. I also understand that I have the opportunity to change this written designation at any time. My selection is as follows:

1A. ☐ I elect NOT to designate another person to receive notice of lapse or termination.

B. ☐ I designate the person listed below to receive copies of any notice of lapse or termination.

C. Name

D. Address: Street City State Zip Code

Primary Beneficiary (If percentages are left blank, all named Primary Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Contingent Beneficiary (If percentages are left blank, all named Contingent Beneficiaries will share equally.)

1A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust
2A. Name	B. % Share	C. Relationship to Proposed Insured	D. Date of Trust

Certification Of Policyowner's Taxpayer Identification Number

Under penalties of perjury, I, the Policyowner, certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen or other U.S. person (defined in the instructions in item 3 of the Certification on the official IRS Form W-9).**

Note: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Tax Reporting On Distributions To Foreign Nationals

While Pacific Life Insurance Company (PLIC) may provide tax information to various United States federal and state agencies regarding certain life insurance or annuity activity, PLIC does not as a matter of course provide such information to any foreign governmental agencies and does not anticipate doing so at this time. Nonetheless, PLIC's tax reporting does not in any way affect the obligations that its policyowners may have with respect to such foreign governmental agencies or under foreign law. PLIC does not provide tax or legal advice, and nothing contained herein should be construed as such.

Remarks

Existing Insurance And Replacement Information For Proposed Insured

	YES	NO
1. Do you have any existing life insurance or annuity contracts, including those with long-term care (LTC) coverage?	☐	☐
2A. Do you have another long-term care insurance policy or certificate (including a health care service contract or health maintenance organization contract), whether existing or pending? (If Yes, provide details in the chart below.)	☐	☐
B. Did you have another long-term care insurance policy or certificate in force during the last 12 months that has terminated? (If Yes, provide details in the chart below.)	☐	☐

Company	Coverage Type		Policy Status			Termination Date
	LTC	Health	Existing	Pending	Terminated	

	YES	NO
3. Are you covered by Medicaid?	☐	☐
4. Have you ever applied for life insurance, long-term care, health or disability insurance and been declined, postponed or offered on a basis other than as applied-for? (If Yes, provide details in Remarks.)	☐	☐
5A. Do you intend to stop premium payments, replace, surrender, forfeit, assign to the insurer, or take a cash withdrawal or loan from any life insurance policy or annuity contract to pay premiums on the applied-for policy? (If Yes, provide details in the chart below.)	☐	☐
B. Do you intend to replace any of your medical or health insurance coverage, including any of your long-term care coverage, with this applied-for policy? (If Yes, provide details in the chart below.)	☐	☐

Policy #	Coverage Type						Company	Amount	1035 Exchange
	Life	Life+ LTC	Annuity	Annuity + LTC	LTC	Health			

General Information (Provide details in Remarks)

	YES	NO
1. Are you working at least 24 hours per week outside the home?	☐	☐
2. Have you missed more than one consecutive week of work due to illness or injury in the past 24 months?	☐	☐
3. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember?	☐	☐
4. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing?	☐	☐
5. Do you have regular exercise routines or hobbies that require physical activity?	☐	☐
6. Do you intend to travel or reside outside the United States within the next 2 years?	☐	☐
7. Have you been convicted of a felony within the past 5 years?	☐	☐
8. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?	☐	☐

Proposed Insured's Physician Information

1A. Provide full name, address, and phone number of ☐ Primary Physician ☐ Specialty Physician

B. Physician Name | C. Telephone # (include area code)

D. Address: Street | City | State | Zip Code

2. Date and reason of last visit:_____

3. Tests performed & treatment received:_____

Remarks

MEDICAL INFORMATION (Provide details to any Yes answers in Remarks. If more space is needed, use an additional sheet.)

	Yes	No
1. Have any of your immediate family members (parents, brothers or sisters) prior to age 60 been diagnosed with polycystic kidney disease or Huntington's chorea?	☐	☐
2. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance, or any other form of disability insurance?	☐	☐
3. Height:_____ Weight:_____ Has your weight changed 10 pounds or more in the past 2 years?	☐	☐
4. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you have needed or required assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?	☐	☐
5. Currently, or within the last 5 years, have you had or do you need or receive assistance with any of the following: laundry, cleaning, shopping, use of transportation, telephone use, meal preparation, managing your finances or managing your medication?	☐	☐
6. Currently, or within the last 5 years, have you had or do you use a wheelchair, walker, cane, quad cane, scooter, oxygen, catheter, dialysis machine, or other mechanical device?	☐	☐
7. Within the last 5 years have you been confined or recommended admission to a nursing home or received home health care, or are you currently confined to a hospital or nursing facility or attended adult day care?	☐	☐
8. Are you currently living in an Assisted Living facility or Independent Community?	☐	☐
9. Within the last 5 years, have you had or been advised to have a check-up, EKG, x-ray, CT scan, blood, or urine test, or any other diagnostic test, except for a test for the Human Immune Deficiency Virus (HIV) infection?	☐	☐
10. Within the last 5 years, have you been a patient in a hospital, psychiatric treatment center, or other medical facility, or been advised or recommended to have any hospitalization or surgery which has not been scheduled or completed?	☐	☐
11. Except for HIV, have you ever been told you have, been diagnosed with or been treated by a physician and/or taken medication for:		
a. Alzheimer's disease, dementia, forgetfulness, memory loss, or any other cognitive impairment?	☐	☐
b. Chest pain, angina, congestive heart failure, heart disease, heart murmur, coronary artery disease, peripheral vascular disease, atrial fibrillation, high blood pressure, or other disorders of the heart or blood vessels?	☐	☐
c. Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Muscular Dystrophy, Huntington's chorea, or Systemic Lupus?	☐	☐
d. Ulcers, colitis, jaundice, cirrhosis, chronic hepatitis, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney, or urinary bladder?	☐	☐
e. Transient ischemic attack, stroke or paralysis?	☐	☐
f. Syncope, vertigo, loss of balance, tremor or falls, seizures, fainting, dizziness, or epilepsy?	☐	☐
g. Chronic fatigue, fibromyalgia, or polymyalgia rheumatica?	☐	☐
h. Any nervous or mental disorder or received counseling for anxiety, depression, schizophrenia, stress, or any other emotional condition?	☐	☐
i. Cancer, leukemia, lymphoma, malignant melanoma, or tumors or cysts of any kind, whether malignant or benign?	☐	☐
j. Arthritis, Rheumatoid Arthritis, gout, Osteoporosis, or any disorder of the back, spine, muscles, nerves, bones, or joints?	☐	☐
k. Diabetes, thyroid, or other endocrine or glandular disorder?	☐	☐
l. Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells, or bone marrow, or any lymph node disorder?	☐	☐
m. Asthma, emphysema, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD), allergies, sleep apnea, or any other disorder of the respiratory system?	☐	☐
n. Any disorder of the eyes, ears, nose, or throat?	☐	☐
o. Any disorder of the testicles, prostate, breasts, ovaries, uterus, or cervix?	☐	☐
p. Any mental or physical disorder not listed above?	☐	☐
12. What, if any, other medications do you take regularly? (Provide details in Remarks.)		
13. Have you ever tested positive for exposure to HIV infection or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS), or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
14. Have you used tobacco products (cigarettes, cigars, pipe) during the past 48 months? If "yes", provide amount used and frequency. _____If quit, when was tobacco last used?_____	☐	☐
15. Do you use alcoholic beverages? If Yes, provide type, frequency & amount:	☐	☐
16. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medications, prescribed or not?	☐	☐
17. Within the last 10 years have you:		
a. Used or tested positive for marijuana, cocaine, heroin, amphetamines, or hallucinogens?	☐	☐
b. Used any tranquilizers, sedatives or narcotic drugs or any prescription drug outside a physician's instructions?	☐	☐

REMARKS

Declarations

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

1. Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by PLIC as indicated under the title Endorsement, where permitted. All other changes made to the application or policy by PLIC will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Producer, whose name appears in the Producer Certification section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
3. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire single premium is paid only if at that time the Proposed Insured is alive, and all answers in this application and on the Statement of Good Health & Insurability that are material to the risk are still true and complete.
4. If I have given money and received a TIA, I understand that if the Proposed Insured dies before a policy is delivered; the death benefit will be limited to the TIA coverage limit.
5. PLIC may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a Department of Motor Vehicle report or other questionnaire, test or a prescription drug or medication report.
6. I must inform the Producer or PLIC in writing of any changes in the health of the Proposed Insured or if any of the statements or answers on this application change prior to delivery of the policy.
7. My statements and answers in this application must continue to be true as of the date I receive the policy.
8. No Producer is authorized to make or change contracts or insurance policies on the behalf of PLIC and no Producer may alter the terms of this application, the TIA, or the policy, nor does the Producer have the authority to waive any of PLIC's rights or requirements.
9. The Producer will receive compensation in connection with the sale of this policy.
10. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Producer or PLIC about the specific premium and risk class referenced in my policy.
11. I represent that all parties have an insurable interest in the life of the Proposed Insured.
12. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
13. The Proposed Insured received the Disclosure Notice and Privacy Notice — Health (HIPAA).
14. I HAVE READ the completed Application and all related forms for [Pacific PremierCare] before signing below. All statements and answers on this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief.
15. For purposes of this application, the proposed insured is considered the applicant, unless a policyowner is also indicated. In such case, the policyowner is considered the applicant.
16. This application will be attached to and made part of the policy.

Inflation Benefit Option

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection.

☐ I hereby **REJECT** the 5% compound Inflation Benefit Option and apply for the Inflation Benefit Option as shown in the Policy Information section, on page 1, question 5.

☐ I hereby **REJECT** all Inflation Benefit Options, including the 5% compound Inflation Benefit Option.

New Business Date Stamp (For Internal Use Only)

Modified Endowment Contract (MEC) Status

The policy is expected to be or become a MEC: ☐ Yes (Policyowner must initial below) ☐ No

Regarding Distributions:

- Distributions from the policy, including those taken during the two years prior to the policy becoming a MEC, can result in earlier income taxation.
- Distributions include (but may not be limited to) pre-death disbursements such as withdrawals, policy loans (including interest not paid when due), surrenders, and cash dividends, and also transfers of ownership and assignment of policy values.
- The taxable portion of any Distribution taken before age 59 ½ may be subject to a 10% penalty by the IRS. This 10% penalty always applies if the MEC owner is not treated as a natural person for tax purposes; e.g. is a corporation or trust.
- For purposes of determining the taxable portion of Distributions, federal tax law provides that all MECs issued by the same insurance company to the same Policyowner during any calendar year shall be treated as one MEC.
- PLIC will report income relating to such Distributions to the IRS as required by federal law and regulations.

Additional Information:

- Once a policy becomes a MEC that status cannot change. Any policy received in exchange for a MEC policy will also be considered a MEC.
- For specific questions regarding the taxation of your MEC policy, please consult your tax advisor.

INITIAL HERE ☐ **By initialing here, the Policyowner confirms their understanding that the policy to be issued is now or will become a MEC at or after issue, and accepts MEC status for the policy.**

Signatures

INITIAL HERE ☐ By initialing here, the Policyowner confirms they received the Outline of Coverage, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Life Insurance Buyer's Guide, and A Shoppers Guide to Long-Term Care Insurance.

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

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

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust) have been met.

CAUTION: If your answers on this application are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

SIGNED IN:

City	State

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE **X**

Proposed Insured's Signature

SIGN HERE **X**

Policyowner's Signature, if other than Proposed Insured, and include **Title,** if Corporation, Trust, or Business Entity.

SIGN HERE **X**

Additional Policyowner's Signature & Title, if applicable

Producer's Certification

	Yes	No
1. Does the Insured have any existing life insurance or annuities, including those with LTC coverage?	☐	☐
2. Do you know or have any reason to believe that a replacement of insurance is involved?	☐	☐
3. I have discussed the appropriateness of replacement, followed applicable state laws, PLIC's written guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If No, explain on an additional sheet.)	☐	☐
4. Based upon my review of, among other things, the Policyowner's and Proposed Insured's age, income, net worth, tax and family status, and current plan of insurance, I certify that the purchase of this policy meets the Policyowner's insurance needs and financial objectives, and is consistent with PLIC's suitability standards. I have documented and will retain my suitability analysis and conclusions.	☐	☐

5. List below any other Health Insurance you have sold to the Proposed Insured that is currently in force, or purchased within the last 5 years and no longer in force. (If No, explain on an additional sheet.)

Company	Policy Number	Year of Issue	Policy Status
			☐ In force ☐ No longer in force
			☐ In force ☐ No longer in force

I have reviewed the application and all related forms with the Insured and Policyowner(s).

SIGN HERE **X**

Soliciting Producer's Signature

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

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(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

STATEMENT OF GOOD HEALTH AND INSURABILITY

Proposed Insured's Name: First MI Last	Policy Number

I certify to Pacific Life Insurance Company (PLIC), to the best of my knowledge and belief, since the date of my [Pacific PremierCare] telephone interview:

1. There has been no change in my health.
2. I am able to perform all activities of daily living without assistance (eating, toileting, transferring, bathing, dressing, and continence).
3. The information on my application is correct and there have been no changes to any of my answers to the questions on my application.
4. I have had no illness or injury, have not been seen or treated by any physician or health care provider except for those identified on my application, and have not been hospitalized.
5. I have not been declined, rated, or postponed for long-term care insurance.

If any of the above statements are not accurate, provide full details, including dates in the Remarks Section below (or attach sheets, if necessary).

Caution: If your answers on the application or Statement of Good Health and Insurability are incorrect or untrue, PLIC may have the right to deny benefits or rescind your policy.

REMARKS

SIGNATURES

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

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE
X
Proposed Insured's Signature

SIGN HERE
X
Policyowner's Signature

SIGN HERE
X
Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

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AUTHORIZATION TO RELEASE INFORMATION

For Individual Life Insurance with Long-Term Care (LTC) Benefits.

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

1. I authorize any physician, health care professional, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, information database manager, other medical or medically related facility, insurance company, health plan, MIB, Inc., consumer reporting agency, state motor vehicle agency, or employer to release to **Pacific Life Insurance Company (PLIC)** its subsidiaries, reinsurers, employees and representatives, any protected health information ("PHI") they may have in their possession or under their control as to the diagnosis, treatment, prognosis of any physical or mental condition (excluding psychotherapy notes), human immunodeficiency virus (HIV) infection, sexually transmitted diseases, treatment of mental illness, and the use of tobacco. Although Federal Regulation protects information related to drug or alcohol abuse from disclosure, I give permission to collect this information. I understand that the reason for releasing such PHI under this paragraph 1 is to determine eligibility for the purchase and administration of a life insurance/long term care policy ("Policy") and that such information will not be released to any person or organization except a reinsurer, MIB, Inc., and other persons or organizations performing business or legal services on behalf of PLIC in connection with my application, or as may be otherwise required by law, authorized under paragraph 2 below, or as I may further authorize.

2. I also authorize PLIC and its subsidiaries, reinsurers, employees and representatives, to release to the policyowner(s) of the Policy or the assignee of the policyowner(s), the producer of record of the Policy, and to the additional authorized recipient I have indicated above, if any, any and all PHI relating to the Policy ("Policy Information") including but not limited to the Policy's values, any withdrawals taken against the Policy, payments for long-term care services, and information required by law to be provided to the policyowner(s). I understand that the reason for releasing Policy Information under this paragraph 2 is to facilitate the administration of the Policy or as is required by law.

3. I understand that I may revoke this authorization at any time by sending a written revocation request to Pacific Life Insurance Company at: [P. O. Box 2030, Omaha, NE 68103-2030]. Such a revocation will not affect (a) any action taken or information released prior to the revocation, (b) any legal right PLIC has to contest the Policy, or to contest a claim under the Policy, (c) any information necessary to service and administer the Policy, or (d) Policy Information that PLIC is required by law to provide to the policyowner(s) . I understand that if I revoke or refuse to sign this authorization, PLIC may not be able to process my application.

4. I understand that PLIC may not condition treatment, payment, or eligibility for benefits on whether I sign this authorization, but PLIC may require that I sign this authorization in the event that I am not both the policyowner and the insured. This authorization is not affected or limited by any prior agreements I may have made with any of the above persons or entities to restrict the release of such information, and I instruct them to release and disclose all such information without restriction. This authorization shall remain in force for as long as the Policy is in force, and a copy of this authorization is as valid as the original. I understand that once any such health-related information is released pursuant to this authorization, that information may be redisclosed and will no longer be covered or protected by the HIPAA rules governing privacy and confidentiality of health information.

SIGNATURES

I acknowledge that I have received a copy of this authorization.

Signed and Dated by the Insured in: _____ _____ _____

City **State** **Date** (mm/dd/yyyy)

SIGN HERE **X** _____

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

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LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy. All references to "you" on this form apply to the policyowner(s). (Complete one form per policyowner.)

PREMIUM INFORMATION

Policy and Rider Form Numbers: [P11PPC – Flexible Premium Adjustable Life Insurance Policy
R11ABR – Accelerated Benefit Rider
R11EBR – Extended Benefit Rider]

The premium for the coverage you are considering will be a one-time single premium of $_____.

Type of Policy: Non-Cancellable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

The company cannot raise your rates on this policy.

RATE INCREASE HISTORY

The company has sold long-term care insurance since 2012 and this policy form since [2012]. The company has never raised its rates for any long-term care policy it has sold.

SOURCE OF PREMIUM

How will you pay for this policy? (Check all that apply)

☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

QUESTIONS RELATED TO YOUR INCOME

What is your annual income? (Check one)

[☐ Under $10,000 ☐ $20,000 - $49,999 ☐ $100,000 - $149,999]

[☐ $10,000 - $19,999 ☐ $50,000 - $99,999 ☐ $150,000 and over]

How do you expect your income to change over the next 10 years?

☐ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Questions Related to Your Income (Continued)

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount? (Check all that apply) ☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

The national average annual cost of nursing home care in [2009] was [$72,270], but this figure varies across the country. In ten years the national average annual cost would be about [$117,800] if costs increase 5% annually. [(Source: National Long-Term Care Clearinghouse, 2009.)]

The elimination period for nursing home care under the rider is 30 days. Based on the year [2009] figures provided above, this means approximately [$6,023] in nursing home costs will be incurred before benefits are payable.

How are you planning to pay for your care during the elimination period? (Check all that apply)
☐ From my Income ☐ From my Savings and/or Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home and premium for this policy, about how much are all of your assets (your savings and investments) worth?

[☐ Under $20,000 ☐ $30,000 - $49,999 ☐ $100,000 - $249,999 ☐ $500,000 and over]

[☐ $20,000 - $29,999 ☐ $50,000 - $99,999 ☐ $250,000 - $499,999]

How do you expect your assets to change over the next ten years? (Check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statements

Check one:	☐ The answers to the questions above describe my financial situation. or ☐ I choose not to complete this information.

☐ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. (This box must be checked.)

Signatures

SIGN HERE X _____ Date (mm/dd/yyyy) _____ Policyowner's Name: First MI Last (print) _____

Policyowner's Signature

☐ I explained to the policyowner the importance of completing this information.

SIGN HERE X _____ Date (mm/dd/yyyy) _____ Producer's Name: First MI Last (print) _____

Producer's Signature

Sign below only if your producer has advised you that this policy may not be suitable for you.

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

SIGN HERE X _____ **Date** (mm/dd/yyyy) _____

Policyowner's Signature

The company may contact you to verify your answers.

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[PACIFIC PREMIERCARE] TEMPORARY INSURANCE AGREEMENT (TIA)

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)

This TIA provides a limited amount of life insurance coverage, for a limited period of time, subject to the Terms and Conditions shown below.

Payment in the amount of $ _____(checks must be made payable to "Pacific Life Insurance Company") is made in connection with this TIA on the life of the proposed insured named above.

Within the past 90 days, has the Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? ☐ Yes ☐ No

If the above question is answered YES or LEFT BLANK, no representative of Pacific Life Insurance Company (PLIC) is authorized to accept money, and NO COVERAGE will take effect under this TIA.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $600,000 MAXIMUM	If money has been accepted by PLIC as payment in connection with this TIA and if the Proposed Insured dies while this TIA is in effect, PLIC will pay the designated beneficiary the amount of death benefits, if any, that would be payable under a requested [Pacific PremierCare] Policy if such were issued, which amount shall not exceed $600,000.
DATE COVERAGE BEGINS	Temporary life insurance under this TIA will begin on the date of this TIA, but only if a request for a [Pacific PremierCare] Policy has been initiated, and payment is received by PLIC on the same date or not more than 10 days prior to the date of this TIA.
DATE COVERAGE TERMINATES (45 DAY MAXIMUM)	Temporary life insurance under this TIA will terminate automatically on the earliest of: a. 30 days from date of this TIA if a required phone history interview is not completed and received by PLIC; or b. 45 days from the date of this TIA; or c. the date any [Pacific PremierCare] Policy is offered; or d. five days after the date PLIC mails notice of termination of coverage under this TIA and refunds the full amount of payment referenced above.
LIMITATIONS	• This TIA does not provide benefits for long term care coverage. • Fraud or material misrepresentation made in a request for a [Pacific PremierCare] Policy or any Application or in the answer to the above question in this TIA invalidates this TIA, and PLIC's liability shall be no greater than the refund of any premium payment made in connection with this TIA. • If the Proposed Insured dies by suicide, PLIC's liability under this TIA is limited to a refund of the payment made. • There is no coverage under this TIA if the check submitted as payment is not honored by the bank on first presentation. • If the Proposed Insured has more than one TIA in effect, the maximum aggregate coverage under any and all TIAs is $1,000,000. • **No one is authorized to waive or modify any of the provisions of this TIA.**

I HAVE RECEIVED A COPY OF AND HAVE READ THIS TIA AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL OF ITS TERMS AND CONDITIONS.

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

Signed and Dated on:

Date (mm/dd/yyyy)

SIGN HERE

X

Proposed Insured's Signature

SIGN HERE

X

Policyowner's Signature, if other than Proposed Insured include Title, if Corporation, Trust or Business Entity

SIGN HERE

X

Producer's Signature

Policyowner's Name: First MI Last (print)

Producer's Name: First MI Last (print)

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.