

SERFF Tracking Number: PNMU-127004312 State: Arkansas
Filing Company: Penn Insurance and Annuity Company State Tracking Number: 47835
Company Tracking Number: 2011 SUPPLICATION APPLICATIONS - PIA
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2011 Supplication Applications - PIA
Project Name/Number: 2011 Supplication Applications - PIA/2011 Supplication Applications - PIA

Filing at a Glance

Company: Penn Insurance and Annuity Company

Product Name: 2011 Supplication Applications -SERFF Tr Num: PNMU-127004312 State: Arkansas

PIA

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 47835
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: 2011 SUPPLICATION State Status: Approved-Closed
APPLICATIONS - PIA

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Nancy Yannuzzi, Rita
Bellew

Disposition Date: 02/02/2011

Date Submitted: 01/28/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2011 Supplication Applications - PIA

Status of Filing in Domicile: Pending

Project Number: 2011 Supplication Applications - PIA

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 02/02/2011

State Status Changed: 02/02/2011

Deemer Date:

Created By: Rita Bellew

Submitted By: Rita Bellew

Corresponding Filing Tracking Number: 2011

Supplemental Applicaitons - PIA

Filing Description:

The Penn Mutual Life Insurance Company and our subsidiary company, The Penn Insurance and Annuity Company, are submitting the following forms for your review and approval:

Form / Title / Form Replaced

PM5696 06/10 / Application for Life Insurance -Guaranteed Issue / PM5696

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PM5776 06/10 / Application for Life Insurance - Simplified Underwriting / PM5776

PM1434 06/10 / Consent to Insure / None

PM1433 06/10 / Master Application for Corporate Life Insurance / None

PS1019 1/11 / Current Health Questionnaire / None

The PM5696 06/10, PM 5776 06/10, PM1434 06/10 and PM1433 06/10 are policy forms that will be used for Corporate Owned Life Insurance policies on groups of executives.

The PS1019 1/11, Current Health Questionnaire, will be used for situations where aged medical information exists and a policy owner is electing to have a rider or benefit added to an existing policy and confirmation of current health status is needed. Additionally, the form will be used at time of policy issue to confirm health status in situations beyond expiration date of medical exams.

Company and Contact

Filing Contact Information

Rita Bellew, State Filing Coordinator bellew.rita@pennmutual.com
VIM C3G 215-956-8290 [Phone]
Philadelphia, PA 19172 215-956-8145 [FAX]

Filing Company Information

Penn Insurance and Annuity Company CoCode: 93262 State of Domicile: Delaware
VIM C3G Group Code: 850 Company Type: Life and Annuity
Philadelphia, PA 19172 Group Name: Penn Mutual Life Ins. State ID Number:
Co.
(215) 956-8893 ext. [Phone] FEIN Number: 23-2142731

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: 50.00 per filing

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Penn Insurance and Annuity Company	\$50.00	01/28/2011	44180279
Penn Insurance and Annuity Company	\$200.00	02/01/2011	44269541

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/02/2011	02/02/2011

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	01/31/2011	01/31/2011	Rita Bellew	02/01/2011	02/01/2011

SERFF Tracking Number: PNMU-127004312 *State:* Arkansas
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Disposition

Disposition Date: 02/02/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Application for Life Insurance - Guaranteed Issue		Yes
Form	Application for Life Insurance - Simplified Underwriting		Yes
Form	Consent to Insure		Yes
Form	Master Application for Corporate life Insurance		Yes
Form	Current Health Questionnaire		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 01/31/2011
Submitted Date 01/31/2011
Respond By Date 03/02/2011

Dear Rita Bellew,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$200.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 02/01/2011
Submitted Date 02/01/2011

Dear Linda Bird,

Comments:

Thank you for your letter.

Response 1

Comments: Please find the additional \$200.00 has been added via EFT SERFF.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$200.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Rita Bellew

Sincerely,
Nancy Yannuzzi, Rita Bellew

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Form Schedule

Lead Form Number: PM5696 06/10

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PM5696 06/10	Application/ Application for Life Enrollment Insurance - Form Guaranteed Issue	Initial		0.000	Final PM5696_060 310.pdf
	PM5776 06/10	Application/ Application for Life Enrollment Insurance - Form Simplified Underwriting	Initial		0.000	Final PM5776_061 710.pdf
	PM1434 06/10	Application/ Consent to Insure Enrollment Form	Initial		0.000	Final PM1434_060 310.pdf
	PM1433 06/10	Application/ Master Application Enrollment for Corporate life Form Insurance	Initial		0.000	Final PM1433_061 710.pdf
	PS1019 01/11	Application/ Current Health Enrollment Questionnaire Form	Initial		0.000	Health Questionnaire .pdf

B. Premium Information (continued)

19. Complete for Universal Life Plans

(a) Initial premium of \$ _____ has been paid in full. Yes No

Number of months: _____

(b) Subsequent 1st year scheduled premium is \$ _____

(c) Subsequent scheduled premium for year two and thereafter is \$ _____

C. Beneficiary Information

20. Beneficiary

(a) Primary (Payable in equal shares to such as survive the insured unless otherwise stated.)

Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship
Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship

(b) Contingent (If no Primary Beneficiary survives the Insured, payable in equal shares to such as survive the insured unless otherwise stated.)

Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship
Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship

(c) If no Primary or Contingent Beneficiary survives the Insured, Payable to the executors of administrators of:

(The Insured, if no one else is named)**D. Owner (Complete only if Owner is other than Insured)**

21. Policyowner Name (First) (Middle) (Last)

Address (Street Address) (City) (State) (Zip Code)

Tax ID Number

Phone Numbers

Trustee's Name (First) (Middle) (Last)

E. Insurance History

22. Total Insurance on Proposed Insured's Life

Company	Amount	Product	Reason for Insurance	Accidental Death Benefit	Issue Date

E. Insurance History (continued)

23. (a) Is insurance applied for intended to replace or change any existing life insurance or annuity policy with any insurance company? Yes No
- (b) If (a) is "Yes", then does any dump-in involve 1035 exchange money? Yes No
- (c) Will premiums for insurance applied for be paid by policy loan from any existing policy? Yes No

F. Fraud Warning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing a false or deceptive statement may have violated state law.

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

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

G. Representation

I represent that the statements and answers in this application are complete and true to the best of my knowledge and belief. I submit them to the Penn Insurance and Annuity Company understanding that Penn Mutual will rely on them in deciding whether or not to approve this application. I also understand and agree that no agent is authorized to make or modify any contract of insurance.

I agree that acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed "Home Office Amendments and Corrections", except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.

Signed on _____ Signature of Proposed Insured

at _____, State of _____ Signature of Applicant if not Proposed Insured

To be answered by agent:

I certify to the best of my knowledge this policy will will not replace or change any existing life insurance or annuity policy now in force.

Signature of Soliciting Agent - Licensed Resident Agent Where Required by Law

Agency Code

Name of Soliciting Agent

Agent Code

State License Identification Number

Agent Identification

Percentage

I. Special Instructions

J. Home Office Amendments and Corrections (For use only if permitted by state regulation)

Please print all answers

A. Proposed Insured			
1. Full Name (First)		(Middle)	(Last) <input type="checkbox"/> Male <input type="checkbox"/> Female
2. Date of Birth (mm/dd/yyyy) / /	3. Social Security Number — —	4. Phone Numbers Home () Work ()	5. Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> Other
6. Home Address (Street Address)		(City)	(State) (Zip Code)
7. Occupation			8. Date of Hire (mm/dd/yyyy) / /
9. Employer Name and Address			
10. Job Title			11. Salary
12. Are you currently engaged in active full-time work, at least 30 hours per week in a normal capacity and not been absent more than 5 consecutive work days to illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain: _____			
13. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g. cigarettes, cigars, pipes, chewing tobacco, nicotine gum or patches, or any other nicotine delivery system) <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give type, frequency, and date last used) Type _____ Frequency _____ Date Last Used (mm/dd/yyyy) _____			
B. Premium Information			
14. Base Policy: (a) Plan of Insurance _____ (b) Amount _____ (c) Death Benefit Option (Universal Life Only) <input type="checkbox"/> Level Death Benefit <input type="checkbox"/> Increasing Death Benefit (d) Premium Test (Universal Life Only) <input type="checkbox"/> Guideline Premium <input type="checkbox"/> Cash Value			
15. Additional Benefits and Riders <input type="checkbox"/> Cash Value Enhancement Rider <input type="checkbox"/> Business Accounting Rider <input type="checkbox"/> Flexible Protection Rider <input type="checkbox"/> Supplemental Term Rider <input type="checkbox"/> Return of Premium <input type="checkbox"/> Other _____			
16. Automatic Premium Loan Option (Traditional Life Only) <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Dividend Option <input type="checkbox"/> Cash <input type="checkbox"/> Other _____			
18. Premium (a) Mode of premium payment <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> Salary Allotment / List Bill <input type="checkbox"/> Other _____ (b) Type of Billing: <input type="checkbox"/> Single <input type="checkbox"/> Group <input type="checkbox"/> Individual			
19. Complete for Traditional Plans (a) Has full payment for the first premium been made? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) For additional Deposit Paid-up Additions only: (1) Lump sum amount of \$ _____ has been paid in full. <input type="checkbox"/> Yes <input type="checkbox"/> No (2) Scheduled amount of \$ _____ has been paid in full. <input type="checkbox"/> Yes <input type="checkbox"/> No (3) Subsequent billing to be scheduled: \$ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No			

B. Premium Information (continued)

20. Complete for Universal Life Plans

(a) Initial premium of \$ _____ has been paid in full. Yes No

Number of months: _____

(b) Subsequent 1st year scheduled premium is \$ _____

(c) Subsequent scheduled premium for year two and thereafter is \$ _____

C. Beneficiary Information

21. Beneficiary

(a) Primary (Payable in equal shares to such as survive the insured unless otherwise stated.)

Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship
Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship

(b) Contingent (If no Primary Beneficiary survives the Insured, payable in equal shares to such as survive the insured unless otherwise stated.)

Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship
Name (First)	(Middle Initial)	(Last)	Social Security Number	Relationship

(c) If no Primary or Contingent Beneficiary survives the Insured, Payable to the executors of administrators of:

(The Insured, if no one else is named)**D. Owner (Complete only if Owner is other than Insured)**

22. Policyowner Name (First) (Middle) (Last)

Address (Street Address) (City) (State) (Zip Code)

Tax ID Number Phone Numbers

Trustee's Name (First) (Middle) (Last)

E. Insurance History

23. Total Insurance on Proposed Insured's Life

Company	Amount	Product	Reason for Insurance	Accidental Death Benefit	Issue Date

E. Insurance History (continued)

24. (a) Is insurance applied for intended to replace or change any existing life insurance or annuity policy with any insurance company? Yes No
- (b) If (a) is "Yes", then does any dump-in involve 1035 exchange money? Yes No
- (c) Will premiums for insurance applied for be paid by policy loan from any existing policy? Yes No

F. Personal Information for Proposed Insured

25. (a) Height (in shoes) ft. _____ in. (b) Weight (clothed) _____ lbs.

- | | Yes | No | Details (if answered Yes) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|
| 26. Within the past 5 years have you: | | | |
| (a) Consulted a physician for any reason; had an electrocardiogram or other diagnostic test? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Been in a clinic, hospital or medical facility for observation or treatment? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (c) Been advised to have any diagnostic test, hospitalization or surgery which was not done? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (d) Is there any family history of cancer, diabetes, heart disease, Huntington's Chorea, neuromuscular disorder, stroke, TIA (transient ischemic attack) or other cerebrovascular disorder? If Yes, give details to include the family member, diagnosis and age at diagnosis. | <input type="checkbox"/> | <input type="checkbox"/> | |

- | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| 27. Have you ever been treated for, or been diagnosed with: | | | |
| (a) Chest pain, high blood pressure, stroke, TIA (transient ischemic attack), heart murmur, palpitations, rhythm disturbance, or other disorder of the heart, cardiovascular or cerebrovascular systems. | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Cancer, cyst, growth, tumor? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (c) Anxiety, depression, dizziness, convulsions, epilepsy or any mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (d) Diabetes, thyroid or other glandular disease? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (f) Breast, prostate or reproductive disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (h) Asthma, emphysema, chronic obstructive pulmonary disease (C.O.P.D.), sleep apnea, or other respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (g) Kidney, bladder or other genitourinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (e) Colitis, hepatitis, or any liver, stomach or other gastrointestinal disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (i) An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), or tested positive for the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> | |

- | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| 28. Have you ever: | | | |
| (a) Used amphetamines, barbiturates, hallucinogens, marijuana cocaine, narcotics, or other controlled substances, except as prescribed by a physician? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Been counseled or treated for use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> | |

- | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| 29. Within the past three years, have you: | | | |
| (a) Flown or taken instruction as a pilot or crew member or intend to do so? (If "Yes", complete Aviation Supplement) | <input type="checkbox"/> | <input type="checkbox"/> | |
| (b) Engaged in any kind of racing, scuba or sky diving, hang gliding, rock climbing or other hazardous avocation or intend to do so? (If "Yes", complete appropriate questionnaire.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| (c) Been convicted of a moving violation, been convicted of a DUI (driving under the influence of alcohol or drugs), or had your driver's license revoked? If yes, | <input type="checkbox"/> | <input type="checkbox"/> | |
| Driver's license number _____ | | | |
| and State of issue _____ | | | |

F. Personal Information (continued)

Yes No Details (if answered Yes)

30. Do you intend to reside or travel outside the United States within the next 24 months?
(If Yes, complete foreign travel questionnaire EXCEPT for vacations of not more than 2 weeks duration, provide complete details including Dates, Destinations, and Duration in the Details section.)

31. Are you currently receiving, or within the past 10 years have you received or applied for, any disability benefits, including Workers Compensation, Social Security Disability Insurance, or any other form of disability insurance?

 G. Fraud Warning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing a false or deceptive statement may have violated state law.

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

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

H. Authorization

I(we), _____ hereby authorize: (a) any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided payment, treatment or services to me(us) or on my(our) behalf; (b) any insurance company; and, (c) the Medical Information Bureau, Inc. (MIB), to disclose my(our) entire medical record and any other protected health information concerning me(us) to the Underwriting Department of The Penn Mutual Life Insurance Company, its subsidiaries, affiliates, third party administrators and reinsurers (herein Company).

I(we) understand that such information may include records relating to my(our) physical or mental condition such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

I(we) acknowledge that any agreements I(we) have made to restrict my(our) protected health information do not apply to the Authorization, and I(we) instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my(our) entire medical record without restriction.

I(we) understand that this information will be used by the Company to determine eligibility for insurance.

I(we) hereby authorize the Company to disclose any information it obtains about me(us) to the Medical Information Bureau, Inc., or any other life insurance company with which I(we) do business. I understand that the Company will not disclose information it obtains about me(us) except as authorized by this Authorization, as may be required or permitted by law, or as I(we) may further authorize. I(we) understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I(we) understand that: (a) this Authorization shall be valid for 30 months from the date I(we) sign it; (b) I(we) may revoke it at any time by providing written notice to the Underwriting Department of the Company subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my(our) authorized representative and I(we) are entitled to receive a copy of the Authorization upon request and (d) a copy of this Authorization shall be as valid as the original.

I(we) acknowledge receiving an MIB, Inc. Notice, a Fair Credit Reporting Act Notice and a Notice of Information Practices and authorize Penn Mutual to obtain an investigative or other consumer report as described in the Fair Credit Reporting Act Notice.

I. Representations

I(we), the Proposed Insured(s), or Applicant(s) if Proposed Insured(s) is(are) age 17 or less, represent that the statements and answers in this part I of the application are written as made by me(us) and are complete and true to the best of my (our) knowledge and belief. I(we) the Proposed Insured(s), or the Applicant(s) if other than the Proposed Insured(s) agree that they will be a part of the contract of insurance if issued; that I(we) will be bound by such statements and answers, and that the Company, believing them to be true, will rely and act upon them. I(we) also understand and agree that:

1. Subject to the provisions of the temporary insurance agreement attached to this application, no insurance will be in force until the first premium is paid in full and the policy is delivered while the health, habits, occupation and other facts relating to the Proposed Insured(s) and to the Payor, if a Payor Benefit is issued, are the same as described in this Part I of the application, any Part II required by the Company and any amendments or supplements to them.
2. Notice to or knowledge of an agent or a medical examiner is not notice to or knowledge of the Company, and no agent or medical examiner is authorized to accept risks, to pass upon acceptability for insurance or to modify any contract of insurance.
3. Acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed "Home Office Amendments and Corrections", except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.

Signed On _____

Signature of Proposed Insured

at _____, State of _____

Please print Applicant's full name

Signature of Applicant if not Proposed Insured

Notice of Insurance Information Practices

Penn Mutual / Penn Insurance and Annuity Company (PIA) wishes to thank you for your application for insurance. In order for us to accurately underwrite this application, it is necessary to obtain some personal information about you. This information is necessary and vital to our business because it enables us to classify each applicant appropriately according to the risk he or she represents.

We at the Company are and always have been acutely aware of the responsibility placed upon us as possessors of private information. We safeguard such information and disclose it only for legitimate business or legal reasons. Below we will outline some of our underwriting procedures and explain certain rights that you have.

How We Collect Our Information

In addition to the information included in the application, the Company, its subsidiaries or its reinsurers will, as a part of our underwriting procedures, collect information relating to any proposed insured's physical and mental condition, health history, mode of living, general character and reputation, personal characteristics, habits, finances, occupation, other insurance coverage or participation in hazardous activities.

This information may be obtained from you personally or from physicians, medical professionals, hospitals, clinics or other medical care institutions which have provided care to you or to members of your family, from the MIB, Inc., public records, consumer reporting agencies, financial sources (such as your lawyer and/or accountant), other insurance companies, agents, friends, neighbors, employers, or business associates. We may obtain this information through exchanges of correspondence, by telephone, or by personal contact.

An investigative consumer report may be necessary. You have the right to obtain a copy of this report and to be interviewed personally as part of this process. If you desire this personal interview, please inform your agent. Should you want a copy of this report, write to us, and we will furnish the name and address of the consumer reporting agency. You may then contact this agency and request a copy. Should an investigative consumer report be obtained, the consumer reporting agency may retain that information in its files. Federal law prohibits such organizations from disclosing such information to other parties without your authorization.

We will also ask you some marketing questions which we will use solely for marketing analysis.

Access To This Information

The information about you, which we obtain and keep in our files, will not be disclosed to others without your authorization except to the extent necessary for the conducting of our business. For example, necessary items of information may be disclosed to persons or organizations which perform a business, professional or insurance function for us.

We may occasionally disclose certain information to a State Insurance Department, or when required, to law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.

Information about you may be given to other insurers, agents or insurance support organizations to enable them to perform a business function concerning an insurance transaction with you, or to help detect or prevent insurance fraud or misrepresentation. For your benefit we may disclose to your physician a medical problem of which you may not be aware. In addition, we may give information about you to an affiliated company so that it can inform you of insurance products or services.

How To Obtain This Information

You have the right of access to this information which the Company maintains in its files about you and which you reasonably describe. Within 30 business days of our receipt of your written request, you may have access to recorded information about you which is retrievable. However, medical information will be released only to a physician whom you designate. Your right of access does not extend to information which relates to and in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding. We will inform you of the nature and substance of the information and identify any institution source which gave us information. If recorded, we will advise you of those persons to whom such information has been disclosed within two years prior to the request, or if not recorded, we will give you the names of the persons or organizations to whom such information is normally disclosed. If you wish, we can arrange for you to see this information or obtain a copy by mail. You may request correction, amendment or deletion of any information in our files pertaining to you, and we will respond within 30 days.

DETACH AND LEAVE WITH PROPOSED INSURED

We will tell you if we complied with your request. If we do not agree with you, we will notify you of our refusal, give you our reasons and give you the opportunity to file a concise statement of dispute with us. Your statement will be sent with any disclosure of the information which we make.

In either event, we will notify any insurance support organization that furnished the information to us and any person whom you designate and who may have received such information within the preceding two years of the dispute regarding the information. Your statement of dispute will be sent to these parties if we did not comply with your request.

Please direct all requests involving the above procedures to the Penn Mutual Life Insurance Company, Attn.: Life New Business Department, 600 Dresher Rd., Horsham, PA 19044. Give your full name, address, date of birth and policy number. You may also call us at (800) 523-0650, and ask for the Life New Business Department.

Fair Credit Reporting Act Notice

As part of our regular underwriting procedures, an investigative consumer report may be obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry will include information as to your character, general health, general reputation, personal characteristics, driving record, criminal activity, and mode of living. As part of your application for insurance, you have authorized the Company to obtain such a report, and you should understand that you have the right to make a written request within a reasonable period of time to the Company's Underwriting Department to receive additional detailed information about the nature and scope of this investigation. You should also understand that upon written request, you will be informed whether such a report has actually been ordered, and if it has, you will be furnished the name and address of the consumer reporting agency to whom the request was made. You may contact this consumer reporting agency and request a copy of any such report.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. The Penn Mutual Life Insurance Company or Penn Insurance and Annuity Company or its reinsurers may, however, make a brief report thereon to the 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 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 in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Reporting Credit Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

The Penn Mutual Life Insurance Company or Penn Insurance and Annuity Company, 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.

DETACH AND LEAVE WITH PROPOSED INSURED

Please print all answers

1. Corporation Name

2. Address (Street Address)	(City)	(State)	(Zip Code)
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I hereby consent to the purchase of life insurance on my life by the Company/Owner listed above and acknowledge and consent to the policy or policies purchased remaining in force after my termination of employment from the Owner. I understand that the Owner will be the owner and beneficiary of the policy or policies, and that any benefits from such life insurance are payable to the Owner. Neither I, my heirs, assignees, estate, nor administrators have any ownership or beneficial interest or rights in the policy or policies or in any policy proceeds, unless the Owner otherwise notifies the insurer.

A. Proposed Insured

1. Proposed Insured Name

2. Date of Birth	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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4. Social Security Number	5. US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------	----------------------------------------------------------------------------

6. Work Address (City)	(State)
------------------------	---------

B. Death Benefit Amount

I acknowledge that the maximum life insurance face amount for which I can be insured at the time of policy issuance is:

\$ _____

C. General Information

1. Are you currently engaged in active full-time work, at least 30 hours per week in a normal capacity and not been absent more than 5 consecutive work days to illness or injury?

Yes No (If "No", give details)

2. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g. cigarettes, cigars, pipes, chewing tobacco, nicotine gum or patches, or any other nicotine delivery system?)

Yes No (If "Yes", give type, frequency, and date last used)

Type _____ Frequency _____ Date Last Used _____
(mm/dd/yyyy)

D. Signatures

I agree that all statements and answers in this consent form are true and complete to the best of my knowledge and belief. I understand that this consent for insurance on my life shall form part of the Master Application for Life Insurance. I authorize the Owner listed above to release any information it has on me to the insurer. This information may be used to determine eligibility requirements.

Signed and Dated by the Applicant in:

_____ State _____ Month / Date / Year _____

X _____
Proposed Insured

Please print all answers

1. Corporation Name			
2. Address (Street Address)		(City)	(State) (Zip Code)
A. Policy Owner			
1. Policy Owner Name			
2. Address (Street Address)		(City)	(State) (Zip Code)
3. Taxpayer ID Number		4. Telephone Number	
5. Trustee's Name (If Applicable) (First)		(Middle)	(Last)
B. Beneficiary			
1. Beneficiary Name			
2. Trustee's Name (If Applicable) (First)		(Middle)	(Last)
3. Date of Trust (mm/dd/yyyy)		4. Taxpayer ID Number	
C. Plan of Insurance			
1. Plan Name		2. Requested Policy Date	
3. Death Benefit Option (Universal Life Only) <input type="checkbox"/> Level <input type="checkbox"/> Increasing			
4. Premium Test <input type="checkbox"/> Guideline Premium <input type="checkbox"/> Cash Value			
D. Additional Benefits and Riders			
<input type="checkbox"/> Cash Value Enhancement Rider		<input type="checkbox"/> Business Accounting Rider <input type="checkbox"/> Return of Premium	
<input type="checkbox"/> Flexible Protection Rider		<input type="checkbox"/> Other _____	
E. Mode			
<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly			
F. Existing Insurance			
Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums on the new policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details and complete appropriate replacement form required by your state.			

G. Correspondence			
1. Indicate where correspondence should be sent. <input type="checkbox"/> Employer <input type="checkbox"/> Other			
2. Indicate name and address below if information is different than the Policy Owner's information.			
Name			
Address (Street Address)		(City)	(State) (Zip Code)

Fraud Warning

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

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

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

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

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

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

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

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

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey: Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

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

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

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

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

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

Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submit an application or files a claim containing a false or deceptive statement may have violated state law.

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

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

Representations

I represent that the statements and answers in this application are written as made by me and are complete and true to the best of my knowledge and belief. I agree that they will be part of the contract of insurance if issued; that I will be bound by such statements and answers, and that the Company, believing them to be true, will rely and act on them. I also understand and agree that:

1. The Consent to Insure Form, Insurance Schedule or Census and any supplemental applications shall for part of the application for life insurance.
2. No insurance will be in force until the first premium is paid.
3. Notice to or knowledge of an agent is not notice to or knowledge of the Company, and no agent is authorized to accept risks, to pass upon acceptability for insurance or to modify any contract of insurance.
4. Acceptance of any policy issued based on this application will be a ratification of any amendments or corrections noted by the Company in the space headed "Home Office Amendments and Corrections", except that if required by state statute or regulation, any change in amount, age, plan of insurance, additional benefits or classification must be agreed to in writing.
5. This information will be used by the Company to determine eligibility for insurance.

Employer Acknowledgements

I acknowledge and understand the possible implications of IRC section 101(j). I further acknowledge and understand that if IRC section 101(j) and 6039I applies, I as the employer must satisfy the requirements included in IRC section 101(j), otherwise, the death benefit associated with policy(ies) may become income taxable. I understand that I as the employer have the responsibility to ensure both current and ongoing compliance with the requirements of section 101(j) and 6039I.

I also acknowledge and understand that I as the employer must engage with independent tax and legal advisors for current information regarding the laws and regulations that may impact me and the life insurance policies and, that Penn Mutual, its subsidiaries, and its producers are not authorized to provide tax or legal advice.

By signing this document, I acknowledge my understanding of this information, and that I have obtained or will obtain from independent tax and legal advisors any advice that I determine is appropriate with respect to the taxation of the life insurance policies.

Certification of Owner's Taxpayer ID #

Under penalty of perjury, I the owner certify that:

1. The number shown in this application as my social security number or taxpayer identification number is correct; and
2. I am not subject to backup withholding because I have not been notified by the IRS that I am subject to backup withholding as a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, or I am exempt from backup withholding.
3. I am a U.S. person (including a U.S. resident alien)

Check this box if you are subject to backup withholding under section 3406(a)(1)(c) of the Internal Revenue Code.

Signatures

Signed and Dated by the Applicant in:

City State Month / Date / Year

Signature of Owner and/or Applicant:

X _____
Owner

Agents Certification

X _____ X _____
Agent Agent

X _____ X _____
Agent Agent

Additional Forms

Submit Agent's Underwriting Report (PM1156) with all applications.

If applying for a variable product, the Supplemental Application for Flexible Premium Adjustable Variable Life Insurance (PM0304R) must be completed.

If applying for an indexed product, Supplemental Application for Indexed Flexible Premium Adjustable Variable Life Insurance (PM0304R) must be completed.

Please Print

To be completed by Insured and, if applicable, Additional Insured

Name of Insured	First	MI	Last
Name of Additional Insured	First	MI	Last
Policy Number			

Since the date of the original application for insurance to the Company, I or any other life insured under this policy have:

- | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|--|
| 1. Had any injury or illness or change in health | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 2. Consulted, been treated or been examined by any physician or other medical practitioner | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 3. Had any change in the use of tobacco or nicotine products | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 4. Been declined or postponed for life, disability, health insurance or long term care or been offered a modified or rated policy with any other company | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Please provide details for any yes answers.

I the insured represent that the statements and answers in this questionnaire are complete and true to the best of my knowledge and belief.

Insured Signature	Signed at (City, State)	Date mm/dd/yyyy / /
Signature of Additional Insured	Parent or Guardian if Insured Under Age 18	
Name of Producer (please print)	Signature of Producer	

Fraud Warnings

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

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

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

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

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

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

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

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

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

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

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

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

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

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